S. Hrg. 103-91

OVERSIGHT OF THE INSURANCE INDUSTRY: BLUE CROSS/BLUE SHIELD—NATIONAL CAPITAL AREA

HEARINGS

BEFORE THE

PERMANENT
SUBCOMMITTEE ON INVESTIGATIONS

OF THE

COMMITTEE ON GOVERNMENTAL AFFAIRS
UNITED STATES SENATE

ONE HUNDRED THIRD CONGRESS

FIRST SESSION

JANUARY 26-27, 1993

Printed for the use of the Committee on Governmental Affairs

S. Hrg. 103-91

OVERSIGHT OF THE INSURANCE INDUSTRY: BLUE CROSS/BLUE SHIELD—NATIONAL CAPITAL AREA

HEARINGS

BEFORE THE

PERMANENT
SUBCOMMITTEE ON INVESTIGATIONS

OF THE

COMMITTEE ON
GOVERNMENTAL AFFAIRS
UNITED STATES SENATE

ONE HUNDRED THIRD CONGRESS

FIRST SESSION

JANUARY 26-27, 1993

Printed for the use of the Committee on Governmental Affairs

U.S. GOVERNMENT PRINTING OFFICE
63-886 cc WASHINGTON : 1993

For sale by the U.S. Government Printing Office
Superintendent of Documents, Congressional Sales Office, Washington, DC 20402
ISBN 0-16-041007-X

COMMITTEE ON GOVERNMENTAL AFFAIRS

JOHN GLENN, Ohio, *Chairman*

SAM NUNN, Georgia
CARL LEVIN, Michigan
JIM SASSER, Tennessee
DAVID PRYOR, Arkansas
JOSEPH I. LIEBERMAN, Connecticut
DANIEL K. AKAKA, Hawaii
BYRON L. DORGAN, North Dakota

WILLIAM V. ROTH, JR., Delaware
TED STEVENS, Alaska
WILLIAM S. COHEN, Maine
THAD COCHRAN, Mississippi
JOHN McCAIN, Arizona

Leonard Weiss, *Staff Director*
Franklin G. Polk, *Minority Staff Director and Chief Counsel*
Michal Sue Prosser, *Chief Clerk*

PERMANENT SUBCOMMITTEE ON INVESTIGATIONS

SAM NUNN, Georgia, *Chairman*
JOHN GLENN, Ohio, *Vice Chairman*

CARL LEVIN, Michigan
JIM SASSER, Tennessee
DAVID PRYOR, Arkansas
JOSEPH I. LIEBERMAN, Connecticut
BYRON L. DORGAN, North Dakota

WILLIAM V. ROTH, JR., Delaware
TED STEVENS, Alaska
WILLIAM S. COHEN, Maine
THAD COCHRAN, Mississippi
JOHN McCAIN, Arizona

Eleanore Hill, *Chief Counsel*
Daniel F. Rinzel, *Chief Counsel to the Minority*
Mary D. Robertson, *Chief Clerk*

CONTENTS

WITNESSES

Tuesday, January 26, 1993

Wednesday, January 27, 1993

Alphabetical List of Witnesses

Page

Exhibit List—Continued

Page

Exhibit List—Continued

Page

Exhibit List—Continued

Page

Exhibit List—Continued

* Retained in the files of the Subcommittee.

OVERSIGHT OF THE INSURANCE INDUSTRY: BLUE CROSS AND BLUE SHIELD—NATIONAL CAPITAL AREA

TUESDAY, JANUARY 26, 1993

U.S. SENATE,
PERMANENT SUBCOMMITTEE ON INVESTIGATIONS,
COMMITTEE ON GOVERNMENTAL AFFAIRS,
Washington, DC.

The Subcommittee met, pursuant to notice, at 11:03 a.m., in room SD-342, Dirksen Senate Office Building, Hon. Sam Nunn, Chairman of the Subcommittee, presiding.

Present: Senators Nunn and Roth.

Staff Present: Eleanore J. Hill, Chief Counsel; John F. Sopko, Deputy Chief Counsel; Mary D. Robertson, Chief Clerk; David B. Buckley, Chief Investigator; Grace McPhearson, Investigator; Alan Edelman, Counsel; Eleni P. Kalisch, Counsel; Harold B. Lippman, Investigator; R. Mark Webster, Investigator; Scott E. Newton, Investigator; Cynthia Comstock, Executive Assistant to Chief Counsel; Declan Cashman, Staff Assistant; Daniel F. Rinzel, Minority Chief Counsel; Mary E. Michels, Minority Counsel; Andrea Kamargo, GAO Detail; Larry Sullivan, GAO Detail; Dennis Clarke, GAO Detail; John Forbes, U.S. Customs Service Detail; Gene Richardson, Agency for International Development Inspector General Detail; Grant Fox, Staff of Senator Cochran; and Jennifer Urff, Staff of Senator Dorgan.

OPENING STATEMENT OF SENATOR NUNN

Chairman NUNN. The Subcommittee will come to order.

This week, the Permanent Subcommittee on Investigations will hold the fourth in a series of hearings on the operations of the Blue Cross and Blue Shield insurance system.

Last July, after hearing testimony covering overall problems with the Blues, our Subcommittee reviewed the circumstances that caused the failure of the West Virginia Plan, which left over 51,000 individuals with unpaid claims. In September, our Subcommittee reviewed the numerous mistakes and management excesses that nearly bankrupted the Maryland Plan which serves over 30 percent of the citizens of that State.

Today, the Subcommittee turns its attention to the operations of Group Hospitalization & Medical Service, Inc., which provides coverage as Blue Cross and Blue Shield in the National Capital Area, to 1.1 million policyholders in the Greater Washington, D.C. area. This plan holds a unique position among the 72 plans that make up

the Blue Cross and Blue Shield system, since it is the only one that is a creature of Congress, operating with a congressional charter, first granted in 1939 and amended in 1984.[1]

It is also worthy of this Subcommittee's attention, in light of the Plan's current financial condition. As noted recently in its own board meeting minutes, representatives of the Blue Cross and Blue Shield National Association have characterized the plan's reserves as "suspect" and "its liquidity as the worse in the system." [2]

Today's hearings come at an opportune time. Only last week, in his Inaugural Address, President Clinton specifically cited the problems resulting from the high cost of medical care in the United States. As President Clinton noted, this is a problem that "devastates families and threatens to bankrupt our enterprises great and small."

Recently released data from the Department of Commerce confirms that our Nation spent a staggering $838.5 billion or 14 percent of our total economic output in 1992 on health care. The Commerce Department report predicts no end in sight if significant health care reforms are not quickly enacted. The report estimates that our Nation will spend 12 percent more on health care in 1993, or approximately $940 billion. It also predicts that health care costs will increase at a 12 to 15 percent annual rate in the near future, and that by 1994 our citizens will spend over $1 trillion on health care costs.

Although today's hearings will focus on the operations of just one Blue Cross and Blue Shield plan, the underlying problems identified by the staff are relevant to understanding some of the sources of our Nation's bloated health care bill. Our staff has now completed the review of three plans in the Blue Cross and Blue Shield system, a system that historically has been viewed as one of the best in providing comprehensive health care coverage at the lowest possible price. Yet, the Subcommittee's hearing record is replete with examples of mismanagement, excessive costs, poor service and a general lack of attention to cost containment.

Our investigation of the District of Columbia's Plan is consistent with this pattern, I regret to report. I expect that the staff testimony this morning will describe more instances of mismanagement, including, very briefly:

—Creating 45 subsidiaries, both here and abroad, almost all of which never made a profit, but, rather, produced losses of over $100 million for the policyholders of the plan;
—Investing over $5 million in a subsidiary in Jamaica at a time when the plan was legally prohibited from repatriating any potential profits or even the initial investment;
—Engaging in joint ventures and accepting insurance risk from insurance companies operating in the former Communist Bloc, including Poland and Russia;
—Travel by one executive to Bermuda, Portugal, Switzerland, and elsewhere to "investigate" the restaurants, beaches and hotels of some of the most exclusive international resorts to

[1] Exhibit No. 1 is retained in the files of the Subcommittee.
[2] Exhibit No. 2 is retained in the files of the Subcommittee.

ensure that they were appropriate for future business meetings, paid at policyholder expense;
—Repeated use of Concorde supersonic jet by senior management, paid at policyholder expense;
—over $1,000 paid for vintage wine and its storage in a local restaurant's wine cellar, paid at policyholder expense;
—Most recently, even after the plan has been in serious trouble and under scrutiny, the payment for a $30,000 retirement gift in November of 1992 to the outgoing president of the plan—all paid at policyholder expense; and
—Also in recent time, April 29, 1992, a $392,000 expenditure to send 127 people to Monterey, California for a marketing incentive meeting.

These are just a few of the string of management missteps and wasteful expenditures that the staff will unfold for us this morning. Individually, most, certainly not all, but most of these instances could be dismissed, if they were simply one individual instance. They might even be called inadvertence. But taken as a whole, they paint a picture of a plan out of control and operating without any interest in providing low-cost health insurance to its policyholders.

The picture that is portrayed also raises a number of policy concerns that go beyond just one Blue Cross and Blue Shield Plan. These include:

—The need to ensure that the officers and boards of nonprofit health insurance companies do not breach their fiduciary duty to utilize policyholders' premiums only for the benefit of policyholders; and
—The capability of the National Blue Cross and Blue Shield Association, a trade association, to effectively monitor the activities of its 72 plans—and I might add here that we certainly want to make clear that some of these plans, I am sure, are in good financial condition.

We do not say that in any way that all the plans are in bad financial condition. But the ones that we have investigated obviously have considerable problems, and I think the policyholders around the country need to understand that these are independent plans, and they are not part of a gigantic system with all of them insuring each other.

We will hear from the National association in this respect. I know they are working on these problems and I know they plan to make some statements in the next several weeks about changes they are planning to make in response to them.

We are also concerned about the overall ability of State insurance regulators to control the excesses in the health insurance arena, and we will be hearing from a couple of those insurance regulators this morning. We are also concerned about the need for Federal safeguards in monitoring the current health insurance system and any future health care system that may be created.

In short, we had better know what we are doing before we revise this system that is now costing us so much, because when we revise

it, we are also going to have to make a number of changes to basically make sure that we don't repeat these mistakes.

In conclusion, I note that the problems that the Subcommittee has identified in these hearings did not occur overnight. They have been festering for some time, in the dark and out of the sight of regulators the public, and, certainly out of the sight of the policyholders. These hearings are meant to shine the bright light of public attention on a problem that has to be corrected if our Nation is ever going to gain control of its spiraling health care costs.

I know that there are strong concerns as to having these hearings in public. I have heard from a number of people who I am sure, had legitimate concern that these hearings should not be public at this time. But I have also listened to other voices.

John Donaho, the Maryland Insurance Commissioner, recently provided the Subcommittee with an update on the consequences of our September 1992 review of the Maryland Blue Cross and Blue Shield Plan.[1] In that update, the Commissioner notes, and I quote him:

"The thorough investigation conducted by your able staff and the public hearings held by you exposed numerous financial and management failures with respect to Blue Cross and Blue Shield of Maryland.

"Without this public exposure, my staff and I would to this day be unaware of the real problems that existed in the Maryland and D.C. plans. As a result, I fully support these hearings and your continuing effort to review other Blue Cross and Blue Shield Plans, including the National Blue Cross and Blue Shield Association.

"At this point, for the first time in several years, Blue Cross and Blue Shield of Maryland is heading in the right direction. The company has finally begun to dismantle wasteful and costly subsidiaries and has begun to devote its energies to the health care insurance business for which it was created in the first place."

It is with this result in mind—to improve our health care insurance system and the D.C. Plan itself and to protect the policyholders—that the Subcommittee believes that these hearings in public are absolutely essential.

Before proceeding further with the hearing and hearing from the staff, I would like to note for the record the splendid assistance and support that Senator Roth and his minority staff.

Senator Roth, we will hear from you at this time.

OPENING STATEMENT OF SENATOR ROTH

Senator ROTH. Thank you, Mr. Chairman.

I commend you for continuing this particularly valuable investigation. I do have a statement and, in the interest of saving time, I will not read it at this time, except to comment that two things greatly bother me about this whole proposition, one being that the cost of health is bankrupting not only the American family, but the United States itself. So it is shocking to learn that in some of

[1] See Exhibit No. 3.a. on page 267.

these situations, those that are supposed to be protecting and helping the consumer are exploiting them.

My other concern is that purportedly we have regulators, and yet, for one reason or another, they do not seem to be adequately doing the job, and that bothers me. We are always looking here to regulate. Sometimes the regulators themselves seem to fail, and there is always some good reason for it, purportedly. But I think we have here a problem of not only exposing what has happened, but asking how we prevent this in the future.

I have little confidence that merely adding another layer of regulators is the answer, and yet somehow we have to deal with the problem in the interest of this country and the people who rely upon these programs. I, too, want to join you in saying that the findings of the misdeeds of a particular Blue Cross do not necessarily condemn others, that these are separate organizations. All we are interested in here is insuring that they help meet our vital health care needs.

Thank you, Mr. Chairman.

PREPARED STATEMENT OF SENATOR ROTH

Mr. Chairman, I commend you and your staff for your continuing efforts in the Subcommittee's ongoing examination of the Blue Cross Blue Shield system. I look forward to today's testimony, and hope that it will help to ensure that Blue cross Blue Shield subscribers here in our Nation's capital are receiving the best service at the lowest possible cost. Last year, I joined with you, Senator Nunn, in cosponsoring legislation to close the legal loophole which had allowed the D.C. Plan to avoid regulatory scrutiny by the D.C. Insurance Commissioner. That loophole, which may have been used to avoid full scrutiny of subsidiary operations, has now been closed. However, since the D.C. Plan does business in Maryland and Virginia, it has also been subject to regulatory oversight by those states, although there may be some question as to the effectiveness of that oversight. In any event, it appears that the D.C. Plan currently faces some serious financial difficulties.

Our efforts here today are directed toward determining how serious the current situation is and how it came about.

Our goal is not to bring about the demise of any Blue Cross Blue Shield Plan, but to ensure that America's health care consumers are receiving the best possible service for the lowest possible cost. As I have noted at previous hearings in this series, it is crucial to remember the separate and distinct nature of each local Blue Cross Blue Shield Plan. Problems which may be identified in one particular plan cannot be generalized to others.

I look forward to hearing from the Staff today about their very disturbing findings concerning the D.C. Blue Cross Blue Shield Plan, and from area regulators about their actions or omissions in their dealings with BCBSNCA.

Many Americans depend upon the Blue Cross Blue Shield system to meet vital health care needs. I hope these hearings contribute towards ensuring the health of this system, and I again commend you, Mr. Chairman, and your staff for your efforts in this most important area.

Chairman NUNN. Thank you, Senator Roth.

Again, thank you for your cooperation and the cooperation of your staff.

Our first witnesses this morning will be staff members of the Permanent Subcommittee on Investigations: John Sopko, Deputy Chief Counsel, David Buckley, Chief Investigator, and Grace McPhearson, Staff Investigator will present the results of the Subcommittee's investigation into Blue Cross and Blue Shield of the National Capital Area.

I am going to ask all of you that are going to be testifying, all of you to stand and take the oath before the Subcommittee: Do you

swear that the testimony you will give before the Subcommittee will be the truth, the whole truth, and nothing but the truth, so help you God?

Mr. SOPKO. I do.

Mr. BUCKLEY. I do.

Ms. MCPHEARSON. I do.

Mr. Sopko, I understand you are going to lead off this morning. I know you have spent thousands of hours on this, so take your time and give us a summary of your findings. I will leave it up to you to call on Dave and Grace, as you see fit.

TESTIMONY OF JOHN F. SOPKO, DEPUTY CHIEF COUNSEL, PERMANENT SUBCOMMITTEE ON INVESTIGATIONS, COMMITTEE ON GOVERNMENTAL AFFAIRS

Mr. SOPKO. Thank you, Mr. Chairman.

Mr. Chairman and members of the Subcommittee, this morning, the staff is prepared to report on its review of the activities of another Blue Cross/Blue Shield Plan, Group Hospitalization and Medical Services, Inc., which does business as the Blue Cross/Blue Shield of the National Capital Area.

On a basis of its 6-month investigation, the staff has found that many of the problems identified in its investigation of the West Virginia and Maryland Plans are likewise present. Our major findings include:

1. That this Blue Cross/Blue Shield Plan has enjoyed the unique status of being a congressionally chartered not-for-profit corporation since 1939.

2. That Congress exempted this corporation from regulation by the District of Columbia Superintendent of Insurance in 1939, a status it enjoyed until October 5, 1992.

3. Historically, the plan operated in the best interests of its policyholders until the mid-1980's, when it fundamentally altered its business plan and began a proliferation of unprofitable subsidiaries and external business ventures.

4. On December 1, 1992, the corporation had 45 subsidiary operations and engaged in business in dozens of foreign countries. The staff has prepared a chart that that is now up, which identifies those 45 entities.[1] On the whole, these ventures proved to be a financial disaster for the plan. The corporation has realized over $120 million in losses directly attributed to these adventures.

5. Staff also found widely excessive expenditures on behalf of senior management. While the corporation was losing tens of millions of dollars a year, its premiums rising and benefits decreasing, its executives enjoyed first-class and supersonic air travel, stayed in luxury accommodations and ate, drank and entertained themselves at policyholders' expense.

6. In addition, the plan ignored or impeded attempts by the regulators and the National Blue Cross/Blue Shield Association of Chicago to determine its true financial integrity and its external business operations.

---

[1] See Appendix C of Staff Statement on page 174.

7. The staff also found that the corporation's board of trustees were negligent in their responsibility to the subscribers to assure that all transactions and businesses were conducted for the sole benefit of the policyholders.

8. And lastly, the staff has discovered that since July, the corporation is reorganizing, accepting its losses and attempting to return to its historic business clients, those located in the Greater Washington, D.C. area.

The staff has also prepared another chart which is now being put up for your review.[1] This chart depicts what quickly became a significant concern for the staff. It shows that the board of directors of the subsidiaries—and the subsidiaries are listed along the left side of that column—for the most part, these directors of these subsidiaries did not consist of outside parties. They, rather, consisted of the plan's managers.

As you can see, and we have marked them in blue as board of directors and red as officers of the subsidiaries, Mr. Gamble, the former President and CEO of the plan was on the board of directors of almost every one of its subsidiaries. Likewise, Mr. Giuliani, who has now succeeded Mr. Gamble, was on the board of directors of most of those subsidiaries.

Chairman NUNN. So if I got your code correctly, if it is blue under the name of the individual, like Gamble or Cook or Giuliani or any of those, if it is blue, it means they are on the board of the subsidiary that is listed on the left. If it is red, they are an officer, and if it is both, they are both officer and director?

Mr. SOPKO. That is correct, Mr. Chairman.

The staff strongly believes that this contributed to the absence of any external oversight of the 45 subsidiaries, and again, the 45 subsidiaries were the major drain on the plan's assets.

One of the major concerns of the staff review concerned the financial viability of that plan. The staff has reviewed GHMSI's financial data for 1985 through 1992. During that period, it incurred losses in all but 3 of the 8 years. The corporation sustained a net loss during the period of approximately $182 million.

The staff has prepared the next chart which contrasts the reserves, which are in blue, and the reserves which are in red over this period of time.[2]

As that chart reflects, the plan's reserves are projected to drastically decline to a negative balance as of December 31, 1992. Now, this is a projection of 1992 data at this time. It will decline to a negative of $25.1 million. It also shows that the reserves have steadily been declining from a high of over $180 million as of December 31, 1985.

Now, during this same period of time, although it is not shown on the chart, the actual enrollment, the number of subscribers remained relatively flat, at about 1.1 to 1.2 million. But the premium income from those subscribers, as you see, dramatically increased on the core business, from $808 million to $1.7 billion. Thus, even with this dramatic increase in premium income, the plan still lost money.

---

[1] See Appendix D of Staff Statement on page 175.
[2] See Appendix E of Staff Statement on page 176.

Certainly, some of this is attributed to the higher medical costs that the plan had to pay for. But our investigation disclosed significant losses attributed to unwise management decisions and questionable expenditures.

As we indicated, the plan's venture into its far-flung subsidiary operations has been its chief financial nemesis. Prior to 1983, only two subsidiaries existed. By August 1992, the management of the plan had embarked upon what one former plan executive called "a frenzy of investment in subsidiary operations."

The staff identified several key factors which contributed to the general dismal performance of most of the plan's subsidiary and affiliate operations. They included:

(1) Little, if any, due diligence was performed before a subsidiary was created;

(2) Instead of capitalizing most of the start-up companies, the plan's subsidiaries borrowed money from financial institutions which the plan then guaranteed;

(3) After the companies were created, management concerned itself solely with revenue and never with the mounting liabilities, rising overhead and losses that were incurring, and rosy and unrealistic projections were presented by senior management to the board of trustees;

(4) Many subsidiaries were ventures in which the management had no suitable experience—as one executive told the staff, "they flew by the seat of their pants and utilized the deep pocket of GHMSI;"

(5) There appeared to be no real accountability on the part of subsidiaries' management, since, as one plan official said, "the plan would always bail us out"; and

(6) The staff found that it appears that some of the subsidiaries were often used as the private playgrounds of senior managers for excessive world trips and other excesses.

Mr. Buckley, our Chief Investigator, will now detail a few examples of the subsidiary activities in light of those overall problems that we identified.

TESTIMONY OF DAVID B. BUCKLEY, CHIEF INVESTIGATOR, PERMANENT SUBCOMMITTEE ON INVESTIGATIONS, COMMITTEE ON GOVERNMENTAL AFFAIRS

Mr. BUCKLEY. Mr. Chairman, the plan invested a total of $6.5 million in Blue Cross of Jamaica. The staff found that this significant investment was done with little prior due diligence to determine either the safety of the investment or the probability of any potential profits back to GHMSI.

Apparently, the motive for this investment had nothing to do with benefiting American subscribers in the Washington Metropolitan Area. The Jamaica investment, in the words of Joseph Gamble, the D.C. Plan's former President, came as the result of a need to "help another Blue Cross plan out," not specifically to benefit the D.C. Plan.

It does not appear that either Mr. Gamble or the GHMSI board knew at the time of the initial investment that the government of

Jamaica did not permit the repatriation of U.S. currency, which would have included the D.C. Plan's investment and any future profits or earnings. Thus, the D.C. Plan had essentially locked itself into a financial investment in Jamaica that it could not get out of nor receive any profit from.

By the time the law changed, unfortunately, due to inflation and poor finances at the Jamaican plan, there were no profits or earnings to repatriate. In sum, the staff found that the plan's involvement in the tangled web of Jamaica will likely result in a loss of their entire investment.

The staff found that EMTRUST, a joint venture between the D.C. Plan and the Fairfax Hospital holding company, INOVA, was ill-conceived, apparently mismanaged and financially troubled from its inception. Created to serve the needs of small- to medium-size self-insured employers in the Metropolitan Washington area, EMTRUST assumed a fiduciary duty to their clients, a duty that the staff believes EMTRUST violated.

EMTRUST was required to subcontract almost all of its functions to its sister subsidiaries. These constraints resulted in EMTRUST clients paying a higher price for services that EMTRUST would have been able to obtain if it had been allowed to contract for the work outside of its parent's corporations. This raises in the staff's mind a question of whether EMTRUST thereby violated its strict fiduciary responsibility to oversee and expend their clients' assets only in the clients' best interest.

The staff believes that EMTRUST may also have violated its strict fiduciary responsibility to its clients in another way. It appears that EMTRUST knowingly commingled its clients' trust accounts and paid the claims of deficit clients by using the positive balances of other clients' accounts. The staff also determined that EMTRUST's business practices were so poor, that it unwittingly paid the claims for clients who had inadequate funds to cover their health expenses.

As with other subsidiaries, the staff uncovered a number of questionable expenditures made by senior officers of EMTRUST which were reimbursed by the subsidiary, even as it operated in red ink. The staff discovered jewelry purchases at Tiffany's for Christmas presents for brokers and wives, a sailing trip to "discuss reinsurance," office Christmas parties and multiple golf outings at Avenel charged to the subsidiary.

Moving on to the International Division of——

Chairman NUNN. Let me ask you a question, Mr. Buckley, on Jamaica. Was there any kind of audit done before they invested in Jamaica?

Mr. BUCKLEY. We found that the D.C. Plan did little, if any, due diligence. If they did, it was meaningless due diligence before they committed the funds of the D.C. Plan into Jamaica.

Chairman NUNN. Was there a later audit?

Mr. BUCKLEY. Yes, there was.

Chairman NUNN. Who did that?

Mr. BUCKLEY. The D.C. Plan, GHMSI's Internal Audit Division performed an audit.[1]

---

[1] Exhibit No. 4 is retained in the files of the Subcommittee.

Chairman NUNN. After they made the initial investment?

Mr. BUCKLEY. Yes, sir. The initial investment was made in 1987, and they conducted their internal audit in 1990 and made significant findings.

Chairman NUNN. What were those findings?

Mr. BUCKLEY. They are numerous, and I will be happy to outline them for you.

Probably the most significant finding in the audit was, that there was a secret slush fund that was being operated by the Jamaican plan's now-former management, then current management, which amounted to about $100,000 U.S. that was used to make political contributions and pay for the excessive expenditures of the corporation's officers. They found bogus overseas travel documentation, wherein the officers would create trips, they would make up travel expenditures and create underlying supporting documents and then file vouchers.

Chairman NUNN. Was this Blue Cross/Blue Shield of D.C. officials, or was this Jamaican officials?

Mr. BUCKLEY. These were Jamaican officials, Blue Cross of Jamaica. There were a host of findings.

Mr. SOPKO. I think, Senator, there were 58 findings made by that internal audit in 1990.

Mr. BUCKLEY. Do you want me to go on with a couple of the findings?

Chairman NUNN. Yes.

Mr. BUCKLEY. They also found potential fraud against the Jamaican government, by overstating accounts receivable and membership enrollments on a Jamaican government employee contract. There was no reconciliation of billings and payments and no adequate recording of premiums. The entire accounts receivable system was "out of control," according to its manager, and there were 58 significant findings down there.

Chairman NUNN. Were these things already in existence before the purchase was made?

Mr. BUCKLEY. That is correct. Those problems, including massive internal control problems and questionable expenditures were in progress and continued after D.C. made its $5 million investment.

Moving on to the International Division of GHMSI, it was responsible for expanding the D.C. Plan's sphere of influence abroad by selling health insurance overseas. The exact amount lost by this venture is hard to calculate, since, amazingly, the International Division did not keep the most rudimentary records until very recently.

However, we do know that the International Division lost over $2 million in 1991 and $6.7 million in 1992.

The staff discovered that the D.C. Plan first ventured into the Caribbean in 1985, offering medical insurance to the citizens of the U.S. and British Virgin Islands, the Cayman Islands, Barbados and elsewhere.

Steven Howard, the International Division's chief financial officer, told the staff that the plan lost money on its Virgin Islands contract, because the rates were very low, the benefits were too high and the plan sold the product in an environment where "there isn't a lot of competition, and these people got dental care

for the first times in their lives." He characterized the Virgin Islands government contract with the D.C. Plan as an absolute nightmare.

After entering the Caribbean market, the plan decided to offer medical coverage to citizens of foreign countries when they traveled from their own country. Simultaneously, GHMSI became more involved in reinsuring other foreign insurance companies than it was in ceding that risk away from itself. The danger here is immense, because GHMSI relied solely on the expertise and due diligence of dozens of foreign insurance companies throughout the world to write the business and pass the majority of the risk back to GHMSI.

In essence, GHMSI gave the power of the pen, that is, the ability to commit the financial resources of the D.C. Plan to foreign insurance companies over which it exercised no direct control. Astounding as it may seem, GHMSI never audited any of the foreign insurance companies to determine if the plan received the appropriate premium due, nor did it verify that the foreign carriers actually paid the claims as they had reported to the plan.

GHMSI relied on these unaffiliated foreign companies to process the applications and forward the premium due to GHMSI. The staff found that the International Division accepted insurance risk on a wholesale basis from foreign insurance carriers, without (1) knowing the specific risk they were assuming, (2) knowing the economic conditions in the countries in which they assumed the risk, (3) knowing how to price the product, (4) knowing at what level to properly reserve for the risk, and (5) without consulting GHMSI's financial advisors, internal or external.

The staff has been told that neither the State regulators nor even the plan to this date understand what happened, what is actually covered and what the actual liability of the plan is.

While the plan's International Division expanded around the globe in search of foreign partners, the plan's Insurance Division headed by David Kestel also created foreign reinsurance companies. Kestel told the staff that he did not want his division's reinsurance commingled with the International Division's business. GHMSI projects a $7 million loss for the Insurance Division for 1992 alone.

The staff found that while the International Division went to the time and expense of creating a joint venture subsidiary with a Lloyd's of London broker on the Isle of Guernsey to cede risk to Lloyd's, the Insurance Division was engaged in its own transactions with Lloyd's of London through a separate broker.

Shockingly, the chief financial officer of the International Division knew nothing about the Insurance Division's forays with Lloyd's until the Subcommittee staff told him last month. Likewise, the chief financial officer for the plan's Insurance Division knew nothing of the International Division's relationship with Lloyd's until the Subcommittee told him. Steven Howard, the chief financial officer for the International Division, called this situation bizarre.

Perhaps the most bizarre transaction, the staff discovered that GHMSI accepted risk from Lloyd's of London. David Kestel, who until very recently ran the Insurance Division, told the staff that

NCRe-Ireland, a subsidiary, began accepting risk from Lloyd's syndicates in 1990, because the syndicates and a broker told him the insurance line was profitable.

Mr. Chairman, we think that this is a bit unique, because Lloyd's of London is not in the business of ceding profitable business outside of Lloyd's. They retain those lines internally to make their own profit. Kestel did not know the identity of the original insurance carriers, the specific underwritten risk or anything else about the business, including whether or not it had been profitable. The staff has now learned that the Lloyd's business has been a loser for the plan, as well.

National Capital Administrative Services, NCAS, is a third-party administrator of medical insurance claims. Since its inception, NCAS has consistently posted net losses and its deficit has grown enormously over the years, from $1.7 million in 1985 to more than $12 million by the end of 1991. GHMSI estimates at least a half-million dollar loss at NCAS for 1992.

Former NCAS Vice President Joe Crowley told the Subcommittee staff that while he could chalk up NCAS' sustained losses between 1985 and 1988 to normal start-up considerations, he did not feel that this rationale could explain the losses thereafter. Mr. Crowley added that he believes this can be explained, at least in part, by the attitude reflected in the words of his boss, NCAS President William Hendren, often expressed to him when he raised questions about company expenditures, "Don't worry, it's the plan's money." This attitude towards GHMSI's seemingly endless deep pocket, rubber money, as Mr. Crowley referred to it, was well known within NCAS, according to other former employees who spoke to the Subcommittee staff.

Additionally, the staff found evidence of false claims having been filed with the U.S. Agency for International Development by NCAS. These claims were investigated by AID's Inspector General, who concluded that the additional reimbursement requested by NCAS was based on "company losses due to underbidding," and not, as NCAS maintained, because of faulty or defective enrollment data submitted by AID. Indeed, the Inspector General reports that, in an interview, NCAS Vice President Joseph Crowley "admitted that the bottom line had been pre-selected and that the supporting schedules were then prepared to fit the selected number."

Former NCAS accounting department employees and I.G. investigators told the Subcommittee staff that a $321,000 claim was virtually the same sum that NCAS lost on the AID contract in 1988. It should be noted that on June 6, 1991, in the presence of another NCAS employee, the former finance and administration director advised NCAS President Hendren that the NCAS claim towards the government was fraudulent and that since he had "signed a certification regarding the information on it, he could wind up in jail."

According to the former employee, Mr. Hendren responded angrily by telling her that NCAS would proceed with the claim, regardless of her concerns. When she persisted in maintaining the action be taken to correct the false and inaccurate information in the claim, she was placed on leave and told she would not be permitted to return to work unless she agreed not to inform anyone

outside NCAS, including government officials, of the improprieties she had found.

The questionable conduct on the part of NCAS in connection with these claims has been the subject of a civil suit brought by the Department of Justice pursuant to the False Claims Act.[1] The suit alleged that the claims were false or fraudulent and were knowingly submitted by NCAS. The suit was settled in October 1992 and provided that NCAS reimburse the government $385,000 and agree to forego its pending claims for adjustment amounting to nearly $400,000 more.

The staff also determined that NCAS managers have been involved in a number of transactions that constitute a conflict of interest. The most serious of these involves the 1991 sale of a financially failing arm of the NCAS network, NCAS Midwest, to NCAS Vice President Joseph Crowley and two other NCAS Midwest employees. The purchase was financed by a direct loan from NCAS in the amount of $250,000. Mr. Crowley and the other new owners did not have to put up any capital and the loan terms were unusually favorable.

While remaining NCAS Vice President, Mr. Crowley became the president of the new entity and continued to serve in these two positions until his termination in November 1992.

The staff's investigation of another company, Protocol, revealed a wholly unnecessary subsidiary which, directly and through its contractual obligations, has been a major financial drain for GHMSI. The staff found that, at year-end 1991, Protocol had accumulated a $6.9 million deficit and GHMSI has an additional $7 million loss for 1992 alone.

Protocol was established to sell health insurance to the foreign embassies and businesses in Washington, D.C., something that the Blue Cross Plan could have done through its own marketing operations. Instead, GHMSI spun off another subsidiary to sell insurance products and place the risk in its offshore reinsurance company, NCRe of Ireland.

A GHMSI internal audit of Protocol was conducted in 1991, revealing serious problems, including the lack of written policies and procedures, the lack of written contracts, problems with accounts payable and receivable, three different billing systems used for one account, and the inability to accurately assess underwriting gains and losses.[1]

The very nature of one of Protocol's contracts raises serious questions and concerns. In its contract, B'nai B'rith was guaranteed $3 million every year for 5 years in return for Protocol getting the account.[2] This is paid to B'nai B'rith, regardless of how much money Protocol makes, if anything, on the contract. In spite of the lucrative nature of this contract, the staff found that Protocol received a virtual flood of complaints from B'nai B'rith policyholders about the lack of service provided by Protocol.

Relations between GHMSI and B'nai B'rith got so bad, that GHMSI tried to smooth things over by holding an executive retreat

[1] Exhibit No. 5 is retained in the files of the Subcommittee.
[1] Exhibit No. 7 is retained in the files of the Subcommittee.
[2] Exhibit No. 8 is retained in the files of the Subcommittee.

in Hawaii involving the leadership of B'nai B'rith, key players of Protocol, GHMSI and other subsidiaries. The trip was held from January 25th through February 2nd 1992. Protocol paid for the majority of the expenses, including those of GHMSI spouses. Hotel expenses exceeded $32,000, and air fare alone paid by Protocol was more than $14,000. While this was allegedly a working trip, golf, deep-sea fishing, sailing and a trip to Maui were also on the agenda.

A review of the schedule reveals that although participants started arriving on January 25th, the first meeting was held on January 29th. Only three 3-hour meetings were held over the 9 days participants were present. The staff questions the propriety of these expenditures, in light of the substantial losses incurred by Protocol and the financial condition of its parent.

This trip was not the only extravagance Protocol was involved in, which included expenditures connected with the Gold Cup, an annual Steeplechase event in Virginia. Protocol also paid over $1,000 for its President's purchase and storage of wine at Morton's of Chicago, despite posting millions of dollars of losses.

Protocol, like all the other subsidiaries, had no external direction or oversight by an independent board. Joe Gamble was Protocol's chairman of the board. Mr. Riley told the staff that when a vote was taken at board meetings, the other board members would look at Gamble and vote as he did. When Gamble raised his hand, they all followed suit. Well, Gamble was apparently aware of this, for at one meeting he started to raise his hand as if to vote, and then brought his hand down across his face, and that gesture was repeated by the other board members at the table. They all believed Gamble was raising his hand to vote.

The Assistance Group, which included World Access and Access America, was one of the largest ventures by GHMSI and, as the staff discovered, one of the biggest financial drains upon the plan. From its creation in 1983, it expanded to include 14 other affiliated or subsidiary companies operating across the globe which provided products as varied as worldwide emergency medical services and lost baggage and trip interruption insurance.

In the course of its existence, the Assistance Group has consistently lost money for the plan and accumulated over $32 million in debt for the subscribers of the D.C. Blue Cross and Blue Shield Plan. The staff's analysis of World Access raised a number of questions, including: (1) The propriety of creating a joint venture with an individual who retained 49 percent interest in World Access and, accordingly, a potential for 49 percent of its profits, even though he made no financial contribution to the venture and bore no financial risk; (2) the wisdom of management rapidly investing plan assets in international ventures without prior experience or adequate due diligence review, and (3) the soundness of continual investment of plan resources into a consistently losing venture.

Mr. Chairman, the staff found that the plan's handling of its Federal contractual responsibilities was replete with instances of inadequate performance and questionable business judgment. These persistent and pervasive flaws in the plan's operations have resulted in tens of millions of dollars in losses, as well as the loss of tens of thousands of subscribers in corresponding market share.

One of the areas in which the staff found major management problems wa sin the plan's handling of the Medicare contract for the Washington metropolitan Area. The plan's poor performance in this regard caused the Department of Health and Human Services to remove the D.C. Plan from the Medicare contract as of March 1988.

Very little concern about the plan's performance was expressed by HHS until the mid-1980's, when a pattern emerged that led the agency to conclude that the plan was not living up to its standards established for Medicare contractors. According to the 1986 evaluation report, the plan failed to meet Federal criteria in two critically important areas, payment safeguards and provider reimbursements and fiscal and contract management, both of which go to the heart of the basic functions and responsibilities of a Medicare contractor, according to HHS.[1] The removal of a Medicare contractor is a very rare occurrence.

Just two contractors were removed prior to 1987, and none have been removed since the D.C. Plan. The staff notes that some of the plan's officers and trustees were misled about the true situation concerning loss of the Medicare contract. For example, according to the May 6, 1990 board of trustee meeting minutes, Mr. Gamble told the board that the plan "got out of the Medicare business in an attempt to save money, because it was unable to recover its total cost." [2]

Gamble never mentioned the plan's poor performance or HHS' reasons for wanting the plan out of the program. The extent of this misrepresentation was further confirmed by the Subcommittee staff in its interviews with the former chairman of the board and the current chief financial officer, both of whom said that, as far as they knew, the plan had voluntarily left the Medicare program, because it was unprofitable.

Mr. Chairman, Staff Investigator Grace McPhearson is now going to detail some of the examples of the plan's excessive administrative expenses.

TESTIMONY OF GRACE McPHEARSON, INVESTIGATOR, PERMANENT SUBCOMMITTEE ON INVESTIGATIONS, COMMITTEE ON GOVERNMENTAL AFFAIRS

Ms. McPHEARSON. Mr. Chairman, the staff's review of GHMSI appears to show a pattern of questionable expenditures. The staff found that excessive spending and outright waste was rampant throughout the plan. Limousines, five-star resorts, exorbitant gifts, expensive hotels, extravagant dining, exotic travel, commissioned artwork, country club memberships and golf outings all at a cost to the subscriber are but a few of the expenditures that the staff will outline here today.

The excessive expenditures discussed may not be illegal. However, they were all incurred at a time when the plan's subscriber rates were increasing, subscriber benefits were decreasing, and the net profitability of the D.C. Plan was shrinking.

---

[1] Exhibit No. 9 is retained in the files of the Subcommittee.
[2] Exhibit No. 10 is retained in the files of the Subcommittee.

Joe Gamble assumed the position of President and CEO of GHMSI in 1985. His total compensation for 1987 was over $264,000. In 1991, just 4 years later, his total compensation was over $533,000. This represents an increase of 102 percent.

The staff has prepared a chart comparing the salaries and benefits of the top 8 executives versus all other GHMSI employees. As the chart depicts, this jump in executive salary was not unusual for those in top positions. From 1988 to 1991, the salaries and benefits of the top 8 executives of the plan rose nearly 85 percent, while the remaining employees of the plan received only a 13.2 percent increase during the same period. Staff notes that Mr. Gamble's compensation package placed him in the top 20 percent of all top executives in the 72 Blue Cross and Blue Shield plans.

The staff's review of GHMSI travel documents identified abundant evidence of questionable domestic and international travel on behalf of the plan's top executives. In 4 years, 1988 to 1991, the D.C. Plan spent over $9 million for travel. In 6 years, 3 of the plan's executives, Joe Gamble, Dick Groppe and David Kestel, were able to establish themselves as international globetrotters, by together billing the plan or its subsidiaries a total of over $1 million for their excursions. Some, if not most, of these trips included first class or supersonic air transportation and deluxe lodging, with seemingly unrestricted food and beverage expenditures.

Mr. Gamble had both the most extensive and expensive travel log of any of the reimbursement records reviewed, though excesses were not limited to him alone. According to Mr. Gamble's date book and travel expense reports, he traveled extensively for the years 1988 to 1991.

For your review, I have prepared three charts that reflect Mr. Gamble's time away from the home office.[1] In 1990, Gamble had his most extensive travel year, in which he was away 202 days of the year or 55 percent of the time. The red blocks indicate the time that he was away from the office. In 1989 and 1988, he was away from the office for 173 and 193 days, respectively.

The total cost of Mr. Gamble's travel to the plan, from 1987 through July of 1992, was a staggering $447,000. His travel raises some concerns about its necessity as well as the wisdom of the plan's CEO being away from his home office for such extended periods of time. Some of these most expensive trips included almost $29,000 spent on a trip to Hong Kong, Singapore and Sydney. The trip lasted 21 days. According to records, Mrs. Gamble accompanied her husband, costing the plan more than $8,000.

He spent over $25,000 on a 23-day trip to China, Japan, Hong Kong, Hawaii, Singapore and London in 1988. Mrs. Gamble again escorted her husband on this trip. A 2-day trip to Paris in 1991 aboard the Concorde, this trip cost the plan over $6,500. Another 2-day trip to Dublin, Ireland in 1989, which cost the plan almost $8,000. Mr. Gamble also traveled to Zimbabwe in 1989. Mr. Gamble attended a conference to give a speech on fraud on the insurance industry. This cost the plan nearly $8,000.[2]

---

[1] See Exhibit No. 11 on page 270.
[2] Exhibit No. 12 is retained in the files of the Subcommittee.

Mr. Gamble not only flew first class as a routine matter. He also frequently flew the Concorde. According to the Subcommittee's review of records, he did so at least 22 times. Mr. Gamble is not alone in his use of the supersonic Concorde. Mr. Kestel, Mr. Groppe and the current President of GHMSI, Mr. Giuliani, also did.

Dr. Charles Duvall, the former chairman of the board of trustees of GHMSI, told the staff that he was not aware of Gamble's frequent use of the Concorde, and if he had been "there would have been a problem." Duvall was also unaware of its use by other plan executives.

David Kestel was another of the plan's frequent fliers, with business scheduled that appeared at times to have limited business content. For example, he made 6 trips that he called site inspection trips. He told the staff that the corporate justification for these trips was to inspect resorts that were potential sites for future marketing incentive trips. His investigative work took him to Bermuda, Portugal, Switzerland, Florida and California. His work schedule for the Portugal visit consisted of inspecting the beaches, golf courses and restaurants of a resort at a cost of more than $5,000 to the plan's subscribers.

The staff learned of another apparent extravagance, the marketing incentive trip which the plan sponsored at great cost to its policyholders. These trips were awarded to various employees of the plan or subsidiary for superior job performance. Portugal, Ireland and Bermuda were but a few of the locations that were chosen for these incentive awards. Several senior executives and their spouses usually attended the trips, in addition to the numerous employees who were actually awarded the trips for their job performance.

The plan justified sending the senior executives along at plan expense, as they would normally give a speech or other presentation to the awardees. Each year for the last 6 years, an award trip occurred. The total cost to the plan was a staggering $1.5 million over 6 years. This includes over $392,000 spent in 1992 to send 127 people to Monterey, California. The staff notes this particular trip occurred after Mr. Giuliani and the board became aware of the serious financial problems at the plan.

The staff found that when first class travel was used, the difference between coach and first class was charged to a separate account called the GHMSI corporate account. The staff believes that the creation and usage of this account amounted to a subterfuge by senior management to avoid close scrutiny of the excessive costs that they incurred at subscriber expense. The total amount of expenses charged through this corporate account for both Blue Cross/Blue Shield of the National Capital Area and GHMSI for 1988 through 1992 was nearly $1 million.

When Dr. Duvall was questioned about his knowledge of the corporate account, he mentioned that he normally reviewed 6-month summaries of the account. He said that basically he was given a stack of documents which roughly outlined what the costs were for and the total amount. He said usually Gamble told him "these costs look good to me, please sign off on them," and he did so.

Of particular concern to the staff is the way the account was reported to regulators. The Subcommittee staff has learned that the plan did not report the corporate account as an expense in its quar-

terly and annual statements filed with their regulators. Instead, the staff found a peculiar accounting practice, wherein the plan listed the expenses paid through the corporate account as other income contra. The staff could not find any valid reason for such a listing of these expenses as income.

The Subcommittee found that the plan commissioned a local artist to create a three-dimensional collage as a retirement tribute for Joseph Gamble. This gift was paid by the plan and ultimately cost its subscribers close to $30,000. Mr. Giuliani approved this extravagance. I believe, Senator, that you have a picture of the collage that is available for review.[1]

Chairman NUNN. This is a picture of it?

Ms. MCPHEARSON. Yes, sir.

Chairman NUNN. What was the cost?

Ms. MCPHEARSON. I believe the actual cost was $28,995.

Chairman NUNN. And what was the date of this?

Ms. MCPHEARSON. It was given to him at his retirement in November of 1992.

Chairman NUNN. November of 1992. Had there already been indications of financial trouble with the plan by then?

Ms. MCPHEARSON. Yes, sir, there had.

Chairman NUNN. And that was known to the board of directors, as well as the officers?

Ms. MCPHEARSON. Yes, sir, I believe so.

Chairman NUNN. Had we already started our investigation at that time?

Ms. MCPHEARSON. Yes, sir, we had.

Chairman NUNN. When did we start our investigation?

Mr. SOPKO. In July of 1992, Senator, we started looking at the D.C. Plan, although in February of 1992, we started looking at the entire Blue Cross system.

Chairman NUNN. So this was a plan that was in very bad financial condition and being investigated by our Subcommittee and perhaps by insurance regulators, and at the same time they gave this $28,000 gift as a going away gift to the president?

Ms. MCPHEARSON. Yes, sir.

Chairman NUNN. Did you find out who authorized that?

Ms. MCPHEARSON. Mr. Giuliani did authorize it.

Chairman NUNN. Can you point out some of the things on this—it looks like this is a picture of the Concorde here, is that right?

[Laughter.]

Ms. MCPHEARSON. Yes, sir. I believe there is a miniature passport on there, golf clubs, a small enterprise, which is what Mr. Gamble had termed the whole GHMSI/Blue Cross network, the enterprise.

Mr. SOPKO. Also can I add, Senator, that around the outside of the collage, which is about 3 feet by 3 feet and about a foot or 6 inches deep, but around the side I believe, in gold, are little flags of every country that Blue Cross/Blue Shield of the National Capital Area had activities in, if I am not mistaken. Also, I think there are 45 brass plates which indicate each of the 45 subsidiaries.

---

[1] Exhibit No. 13 is retained in the files of the Subcommittee.

Chairman NUNN. If I can read this, it says, "To Joe Gamble, in commemoration of your 35 years with Blue Cross and Blue Shield of the National Capital Area, an for your visionary leadership." Right?

Ms. MCPHEARSON. Correct.

Senator ROTH. Could I ask just one question, Mr. Chairman?

Chairman NUNN. Yes.

Senator ROTH. You mentioned that your group started investigating in 1992, was it?

Mr. SOPKO. That's correct.

Chairman NUNN. I believe it was earlier than that, wasn't it?

Senator ROTH. It was earlier than that, 1991?

Mr. SOPKO. On Blue Cross itself, we started in the beginning of 1992. We have been doing insurance fraud for 2 years.

Senator ROTH. But in this particular case here, the D.C. one.

Mr. BUCKLEY. We served the Subcommittee subpoena on the D.C. Plan in July of 1992.

Senator ROTH. Have you any feeling how early there was any knowledge that this organization was in difficulty?

Mr. SOPKO. By us or by the plan, Senator?

Senator ROTH. By the plan or by the regulators.

Mr. SOPKO. Well, the former chairman of the board and also Mr. Giuliani indicate that they realized there were problems with the finances I believe in February of 1992. Now, there clearly were indicators that the National association had and the regulators had going back a number of years that this plan was in dire—was in trouble, I wouldn't say was in dire straits, but it was losing money. It was hemorrhaging money from these subsidiaries going back to the day they were created. So somebody has known that there were problems going back to 1985 or 1986.

I don't know if you want to add to that, Dave, but——

Mr. BUCKLEY. We were told that the board of trustees were consistently provided with rosy projections on the financial ability of the subsidiaries and they basically trusted their management team to give them the straight scoop, as the regulators trusted that the annual filings were accurate, because they are provided under oath, and the National Association of Blue Cross and Blue Shield in Chicago trusted the representation of one of its member plans.

Senator ROTH. If I understand, there could have been knowledge as early as 1985 that this plan was in trouble.

Mr. BUCKLEY. No one bothered to peel back the onion. They just took it on its face and its face said it was doing all right. But internally, management surely knew that they were losing money.

Senator ROTH. Mr. Sopko mentioned the regulators had knowledge.

Mr. SOPKO. I think from the financial statements and the data coming in, you have to realize that the D.C. regulator had absolutely no access to this information.

Senator ROTH. I understand that.

Mr. SOPKO. But in the financial statements, there were indications that these subsidiaries were losing. Now, they—and by they, I mean the plan itself—did not go out of its way to identify these losses to the regulators, to be honest about that. The regulators

weren't given a true picture, but reading between the lines, you could see that there were some losses occurring at that time.

Chairman NUNN. Do you have any indication of when the National Blue Cross and Blue Shield Association knew about the financial difficulties of the D.C. Plan?

Mr. BUCKLEY. Senator, it became apparent to the National association in 1991 that this plan was having problems, and the reason that it took so long is because the plan was only reporting its core business, Blue Cross and Blue Shield business to the National Association in Chicago, so they only saw the at-risk D.C. business. They didn't see the rest of the GHMSI entity that they had in fact licensed to use their trademarks. The plan was not reporting that data to them.

Now, from 1985 through 1990, the D.C. Plan was all over the world registering the Blue Cross and Blue Shield trademarks. They were having an internal squabble, Chicago and D.C., over the legitimacy of D.C. planting the Blue Cross and Blue Shield flag abroad. The Chicago association sued the D.C. Plan, and in 1991 won that lawsuit, and in 1991 it was appealed and upheld. So during this entire 5- or 6-year time frame, they were at odds and fighting each other and the D.C. Plan was not reporting all of its activities to the National association, so that is Chicago's excuse for not knowing what was going on here.

Ms. MCPHEARSON. In addition to Mr. Gamble's retirement gift, there was a retirement dinner held at Congressional Country Club that cost the plan more than $2,800. This brings the total amount of his retirement gift and celebration to more than $31,000 in subscriber funds.

Charles Duvall, former chairman of the board, was asked if he or the board was aware of the extravagant gift for Mr. Gamble. His reply was curt: "I found out about it. I don't know who made the decisions regarding the gift or when they were made, but it had obviously been in the works for a long time. I can't defend it. I find it excessive. He should have gotten a set of golf clubs."

The staff reviewed the plan's expenses at a variety of clubs and hotels in the Washington, D.C. area. The plan, as a fringe benefit to many of its officers, paid the initiation fees and partial dues for membership in area clubs. The staff discovered that in some cases this fringe benefit was taken to extremes, when golf balls and greens fees became regular charges.

Additionally, banquets, parties and seminars caught the staff's attention both for their volume and cost to the plan's subscribers. For example, the plan hosted two costly holiday parties in 1989 and 1990. Each of these events was organized for approximately 150 people and featured floral centerpieces, gulf shrimp, beef tenderloin, veal and salmon. The bar bills alone totalled over $9,000, for a total expense to the plan for these two parties in excess of $34,000.

The plan spent at least $102,000 at the City Club of Washington, a business club in the District, for food and beverage. The plan owns 10 corporate memberships at the club. Two of the plan's officers, David Kestel and Ben Giuliani, had memberships at the Congressional Country Club.

The staff determined that between the two men, at least 11 party orders were paid for by the plan, totalling over $13,000 for confer-

ences, business meetings or retirement parties. Mr. Giuliani joined the club in 1988 for a fee of $10,000 paid by Blue Cross and Blue Shield. From 1988 to 1992, David Kestel amassed bills greater than $10,000 exclusively for golf and golf related items, and submitted them to the plan as local business expenses.

While the Subcommittee staff recognizes that a certain amount of business may be conducted in such settings, we wonder if Mr. Kestel actually had his office at Blue Cross/Blue Shield or at a local golf course. Kestel told the Subcommittee staff it had been agreed to long ago between him, Gamble and Giuliani that where he conducted business didn't matter and that it could be charged to the plan.

The Subcommittee additionally reviewed records from the Tournament Players Club and found that David Kestel had significant charges there, as well, which he billed the plan for. These bills, totalling approximately $44,000 for December 1987 to November 1992, were sent directly to Blue Cross/Blue Shield of the National Capital Area for payment. Items that were regularly paid for by the plan included golf balls, range balls, cart rental, guest greens fees, charges to the Players Pub, headgear, golf outings, dining expenses, amusement taxes, locker rentals and dues. In one instance, a luncheon accounted for more than $3,000 in charges. There were also instances in which shirts and sweaters were charged to the account.

One example of the type of questionable marketing expenses that have come to the Subcommittee's attention involved Protocol sponsorship of the International Gold Cup races held in The Plains, Virginia. The Golf Cup races are a program of 7 horse races sanctioned by the National Steeplechase and Hunt Association. The races are known throughout Virginia as a fashionable event that attracts and up-scale clientele that enjoy catered food and horses.

Over a 3-year period, Protocol spent more than $58,000 on this event. In July of 1992, shortly after our first hearing, Race Chairman Langhorne Bond received a call from Protocol stating it "had not budgeted" for the 1992 race and would not be able to participate. However, the sponsorship contract had no provision for cancellation, and Mr. Bond thus determined that Protocol was locked into the agreement. Protocol was notified of this by letter.

During an interview with Hollings Riley, the former President of Protocol, he told the staff that Ben Giuliani made the decision to "lower Protocol's profile" at the race. Gold Cup officials said that during conversations with Protocol regarding its wishes to disassociate with the Gold Cup races, it became evident that the company was "concerned about appearances." Gold Cup officials said that the publicity that some Blue Cross and Blue SHield plans were receiving regarding extravagant expenses was very clearly unnerving Protocol personnel and Protocol made it very clear that the "company's name" could not be used in conjunction with the 1992 event.

Mr. Chairman, Mr. Sopko will now review the issues dealing with oversight of the plan.

Mr. SOPKO. Mr. Chairman, the first line of oversight in any plan, especially a plan such as this, has to be the board of trustees. The staff believes that the board was negligent in its duties and was coopted by the management it was charged to control. Rather than

delve into the hard-core financial issues related to the creation of many of the subsidiaries, the board accepted management's projections and approved its practices. Although perhaps well intentioned, the board members never took their jobs serious until it was too late.

The staff found from a review of the board minutes and form interviews that it was only upon learning that they could possibly be liable for their potential negligence, did the board members become concerned enough in 1992 to hire an outside consultant to advise them, and in July 1992 voted to increase their directors and officers liability coverage. In some board meetings, discussions of potential liability appeared to have been the most important topic of discussion.

In January of 1985, the board, at Gamble's suggestion, voted to compensate itself. Only two board members refused to go along with the stipend. According to one former board member who refused payment, he said it was wrong for a nonprofit corporation to pay its board, because the board then "gets too close to management."

According to this same trustee, once the other trustees received money from Gamble, they stopped acting as individuals and became Gamble's yes men. Although there were bankers and lawyers on the board, no one asked for documentation to support most of Gamble's business ideas. Gamble's requests were "rubber stamped," according to some former board members.

In the course of approving new subsidiaries, it does not appear from the board minutes or interviews with former board members that the trustees adequately considered the funding necessary to reach a break-even point or to ever obtain profitability. The board also failed to insure that management established adequate internal controls to monitor and administer subsidiaries or obtain credible actuarial data necessary to establish adequate premium schedules.

The staff found that the board meetings, which were typically held every 2 months, began at 6 p.m. with cocktails, followed by dinner served at 7 p.m. Only after the board members had finished dining, did the actual meeting begin at around 8–8:30, and usually ended at about 10–10:30. During the board meetings, the financial report was given very quickly and without substantial discussions. Former board members told the staff that most times Gamble had already created a subsidiary or was well on his way to purchasing one, before the board was aware or could protest.

Dr. Charles Duvall, the former chairman of the board, told the Subcommittee staff that when the subsidiary activity was presented, it usually focused on "the big picture," rather than the finances involved. Gamble's style was to brief the board on an idea, then tell the board that they had to vote on it that same night. One former member complained that the board never had any time to think things over.

In other situations as previously alluded to, Mr. Gamble apparently misled his board. For instance, Gamble always assured the board that the subsidiary costs were not being charged to the plan's reserves, even though the loans to the subsidiaries were being guaranteed by the plan. One former board member said that

Gamble told the board the plan was not paying interest on the lines of credit which it had extended to its subsidiaries, that it was only securing the loans with the banks. The board later determined that this was not true, once the subsidiaries were unable to make the payments.

Dr. Duvall also told the staff that he did not become alarmed about the state of the financial affairs until February 1992, when another trustee presented the board with a spreadsheet that showed the plan was losing money and that projections were looking grossly different from what the board expected. According to Duvall, as a result of this revelation, the chairman and the other members of the board became concerned about not only the plan's finances, but also their own liability.

Coincidentally, as I mentioned before, the staff notes that this time in February was also the same time that the Subcommittee began its preliminary inquiry into the Blue Cross/Blue Shield system. Because the board felt that they were "exposed," the former chairman—that is Dr. Duvall—decided to hire an outside consultant, McKinsey & Company, which would report directly to him about the state of the plan.

The staff finds it significant that the former chairman told the Subcommittee staff that, in retrospect, he realizes the board did not have adequate information with which to act. The former chairman of the board also told the Subcommittee staff that he did not even know the plan was being monitored by the National association until Mr. Giuliani informed him in the spring of 1992.

In fact, he was surprised when the Subcommittee staff told him that the National association had been monitoring the plan since 1988. It appears that the National association had also never informed the board of this fact until the fall of 1992.

The second level of oversight that the staff has determined to have failed in its responsibilities is the National Blue Cross Association of Chicago. A review of the dealings between the National association and the plan, from 1986 through mid-1992, raises a number of questions about the oversight of the National association and its ability to enforce its own membership standards.

The staff has a number of conclusions about that role. They include:

—The association's minimum financial standard for its members is insufficient;

—The association has difficulty in adequately enforcing its own internal controls;

—The association can apparently be prevented from obtaining adequate financial information to effectively monitor a plan if it is involved in a lawsuit with that plan, as it was with the Blue Cross/Blue Shield Plan in the National Capital Area;

—The association also appears to be uninterested in plan subsidiaries that are unrelated to the core business, unless they cause severe financial strain to the plan;

—The association failed to determine the financial condition of GHMSI's subsidiaries and the resultant financial impact on the parent plan;

—The association may be incapable of financially assisting its member plans when they run into financial trouble, and;
—The association has historically failed to share its information with the regulators and the independent boards of the various plans.

The National association told our staff that three words best characterized the D.C. Plan and its attitude toward the National association. Those three words were "uncooperative, difficult and non-disclosure." The staff notes that, even in the face of the plan's obstructionist behavior, the National association was either unwilling or unable to force more thorough compliance with its own internal regulations.

It appears that the association has little enforcement capability, short of moving to revoke the trademarks of the plan, the ultimate weapon. Since it would mean "pulling the license" of a plan, it can never be practically used by the association, without causing major disruption to thousands of people and tarnishing the Blue Cross/Blue Shield public image.

The staff notes that a representative of the National association's monitoring team who monitored the D.C. Plan told the staff that she did not understand the full extent of the plan's subsidiary activity, including its foreign reinsurance business, until December of 1992. And from the surprise on their faces during interviews with the staff, it seems the National association is still learning.

The last line of defense for policyholders is the State regulator. As previously explained, the plan was exempt from regulation by the District of Columbia, its place of domicile, until passed in September of 1992, changing its congressional charter. The staff has been informed that the District of Columbia is now moving quickly to draft appropriate regulations to oversee the operations of GHMSI.

The plan has in the past been examined and partially overseen by a patchwork of State regulation that was inherently inadequate. Because it is licensed in Maryland and Virginia, those regulators applied their rules to the D.C. Plan for that portion of the plan's business sold within their respective States. This situation is unique in the regulation of the insurance industry. Normally, regulators rely on the regulator of a company's "state of domicile" to conduct primary oversight and control over an insurance carrier, and, through it, ultimately authority to rescind its license or place the plan into receivership or rehabilitation.

Of course, such was not the case with GHMSI, since D.C. lacks such authority.

The staff has found that the plan apparently became quite adept at playing the three jurisdictions off each other. Steven Foster, the Virginia Insurance Commissioner, told the staff that he has never experienced the level of difficulty in regulating an insurance company that he historically had with GHMSI.

In a July 1992 interview, Commissioner Foster told the staff that he felt GHMSI's representatives had consistently misrepresented GHMSI's financial and business activities to him. Similar statements on the lack of cooperation were provided by the Maryland and D.C. Insurance Departments. The staff found that because D.C.

lacked regulatory authority over the plan, the Maryland and Virginia Insurance Departments alternated responsibility for examination of the plan.

On February 21, 1992, the Virginia Department of Insurance initiated the most recent on-site review of the plan to identify the issues that would be investigated during the full quadrennial examination.[1] The staff has learned that the Virginia regulator, based on its recently completed examination, intends to lower GHMSI's 1991 year-end reserve by $47.3 million. The plan has reported its reserves at $101 million at year-end 1991.

Chairman NUNN. This is comparable to the 1992 figure which you projected was going to be below the line, right?

Mr. BUCKLEY. There are two separate accounting principles involved here, as we have learned over the past 2 years in looking at this industry, Mr. Chairman. Mr. Sopko's figures he just gave you are based on statutory accounting principles. The figures that we had up earlier, going to a negative $25 million for year-end 1992, are based on generally accepted accounting principles, what everyone uses, GAAP, so these figures are based on prescribed and permitted by the State Insurance Commissioner.

Mr. SOPKO. And adding to the problem, Senator, is that each State has different statutory reserve requirements. D.C. has one. As we found out in Maryland, it was only, I believe, $70,000. So it is different in each State.

Mr. BUCKLEY. The requirements are different in every State, and the application of law varies not only from State to State, but from company to company within a state, so that the system has inherent flaws in the regulation of the industry, not just Blue Cross.

Mr. SOPKO. I am certain Commissioner Foster will go into more detail in his presentation as to their findings and the problems that he has identified. But one point the staff would like to make, just to clarify a prior question, is that each of these regulators, as you say Maryland and Virginia, as we have already discussed, reviewed the operations of the D.C. Plan in their jurisdiction.

The other thing to realize is that each of these regulators also had their hands full with their own Blue Cross/Blue Shield plan during the mid-1980's, and, as we had hearings in September of 1992, the problems of the Maryland Commissioner, he had to devote full-time attention to the problems of his own Maryland plan.

So this unique situation of them being in a domicile State with no regulatory authority while operating in three different jurisdictions contributed, in part, to the problems that we are discussing today.

In sum, Senator, the Staff makes the following conclusions. To start off, the absence of effective regulation inadvertently imposed by Congress permitted excesses and mistakes by the plan's management and board to go undetected and unchecked for 8 years.

The plan's wild expansion into foreign and domestic subsidiaries seriously impacted the finances of the plan.

---

[1] Exhibit No. 15 is retained in the files of the Subcommittee.

The plan's officers committed gross errors of judgment and ignored the most basic tenets of good management. The board of trustees approved these excesses and failed in its duty to assure that all business was conducted for the benefit of the subscribers.

The Blue Cross and Blue Shield National Association also failed to adequately monitor and assess the operations of this plan, thereby endangering its subscribers.

The current regulatory scheme for this plan still remains cumbersome and inadequate. In turn, the staff recommends that the District of Columbia should act swiftly to enact the appropriate legislation or regulations necessary to control this company, and, secondly, the company should be incorporated by and in the District of Columbia, and once that is accomplished, Congress should enact legislation dissolving its congressional charter.

That concludes our oral presentation, Mr. Chairman. We ask that the full statement with appendices be admitted into the record, as if read, along with the additional statements from the Maryland Hospital Association,[1] the Maryland Insurance Department,[2] and others.

Chairman NUNN. Without objection, your entire statement will be submitted for the record and will be included in the record as well as the exhibits.[3]

Do you have any kind of chart showing the premium increases that took place during this period of time? While the revenue was going up, the bottom-line surplus was going down, what was happening to the premiums?

Ms. MCPHEARSON. No, sir. We do not have a chart prepared, but I can give you some examples to show you what the rate increases were like.

You have to realize that the accounts would be either group accounts, small or large, or non-group accounts, and I can give you some examples.

From 1988 to 1991, the premium rates for non-group subscribers as a family rose from $194 to $410 a month.

Chairman NUNN. Per month?

Ms. MCPHEARSON. Yes, sir. At the same time, large group accounts, such as the National Geographic Society employees——

Chairman NUNN. Now, what was the period of time you are covering here?

Ms. MCPHEARSON. That would be a difference from 1988 to 1991.

Chairman NUNN. From 1988 to 1991, the premium on what size family?

Ms. MCPHEARSON. This would be a non-group subscriber as a family. I do not think there is any definition.

Chairman NUNN. Non-group subscriber, just ordinary family getting Blue Cross/Blue Shield went from what per month to what per month?

Ms. MCPHEARSON. $194.06 to $410.90.

Chairman NUNN. So, in this period of time, the premium on the non-group family went up over 400 percent?

---

[1] See Exhibit No. 14 on page 273.
[2] See Exhibit No. 3.a. on page 267.
[3] The prepared Staff Statement and information appears on page 113.

Ms. MCPHEARSON. Yes, sir.

Chairman NUNN. Four times; is that right?

Ms. MCPHEARSON. Yes—no, no, no.

Chairman NUNN. Repeat the numbers again.

Ms. MCPHEARSON. OK. $194 to $410.

Chairman NUNN. OK. $194 to $410. It about doubled in that period of time?

Ms. MCPHEARSON. Yes.

Chairman NUNN. OK. Go ahead.

Ms. MCPHEARSON. OK. At the same time, National Geographic Society employees, which would be a large group account, saw their subscriber rates increase, and this is an individual—not looking at families, but an individual participating as a group—saw from 1988 to 1991 their rates increase from $82.45 to $156.00 a month, so almost double.

Mr. BUCKLEY. Senator, this chart does graphically depict that, because the subscriber base for the Blue Cross/Blue Shield National Capital Area remained fairly constant. It only varies between 1.1 million people and 1.2 million people, back and forth. So that relatively constant number of policyholders, you can see the increase based on the premiums.

Chairman NUNN. Right. Do you find any evidence that any of these subsidiaries made money?

Mr. BUCKLEY. A few, certainly, did. Health Management Strategies International, although it had some start-up cost and was operating in a deficit position initially, has made some money for the parent corporation. That is principally due because of its Federal contract with CHAMPUS.

Capital Care, their HMO, although in a deficit position of approximately $20 million at year end 1991, made money in 1992. So its deficit position is $15.8 million now. They are projecting continued gains there.

Aside from that, it is pretty hopeless.

Chairman NUNN. What was the overall picture? If you include what was lost with the subsidiaries and then what was gained by those that made money, what was the net amount of loss from the subsidiary operations?

Mr. BUCKLEY. They have lost approximately $118 million on that.

Chairman NUNN. Net?

Mr. BUCKLEY. Net.

Chairman NUNN. That is offsetting the losses with the profits from the ones that made profits?

Mr. BUCKLEY. Yes, Senator.

Chairman NUNN. That is over what period of time?

Mr. BUCKLEY. Well, they started their subsidiary explosion. The first one was 1983, when they went international with World Access. But, primarily, between 1986 and especially 1988 and 1989, that is when they really geared up and created a lot of subsidiaries.

Chairman NUNN. Did any of the insurance commissioners have knowledge of or jurisdiction over these subsidiaries? Did Virginia or Maryland insurance commissioners, either one, get the information about what was happening to the subsidiaries?

Mr. BUCKLEY. It is a yes and no answer. The plan files an annual financial picture—it is called a statutory blank—with all three reg-

ulators at the beginning of the year, closing out the previous year. And the back of that schedule, if you recall the July 2nd hearing that we held, we had the financials for the D.C. Plan at that time, and it showed 18 subsidiaries. It listed 18.

So they knew that this plan had its subsidiaries, and some of them were located abroad. The only problem is the financials, as I am sure the regulators will testify, the financial characteristics in that report are grossly misleading, because the numbers do not wash at all.

Chairman NUNN. You said they revealed 18 subsidiaries. How many are there?

Mr. BUCKLEY. Well, at that time, in July, there were 43. They created two more after we subpoenaed them. So there are actually 45.

Chairman NUNN. So they did not show all of them?

Mr. BUCKLEY. No, that is absolutely correct. They did not. But to be fair, the regulation does not require them to show investments, which are less than some calculation; 1 percent of their gross revenues or something like that.

Chairman NUNN. So you think they officially complied with the statute?

Mr. BUCKLEY. Absolutely not. Virginia requires them to obtain advance approval before they invest substantial monies in any operation, and I think that Virginia has found several, if not a half-a-dozen or more, violations of their holding company act, because this corporation did not seek prior approval. They just went ahead and did it.

Chairman NUNN. Ms. McPhearson, what are the excesses? You have listed a lot of them here this morning. In your mind, what are the ones that stand out in terms of the abuses, in terms of expenditure?

Ms. MCPHEARSON. My choices are rather broad here, but I would begin with Mr. Gamble's collage that we have heard about, Mr. Giuliani's $10,000 initiation fee at Congressional Country Club, Mr. Kestel's site inspection trips that I spoke with you about. He took eight trips. That cost the plan more than $14,000.

The supersonic airfare has raised a few eyebrows. We are estimating that Mr. Gamble took it 22 times at a cost of $66,000 to the plan.

I mentioned the marketing incentive trips. There were six of them, and that cost the plan $1.5 million. You could basically consider——

Chairman NUNN. Were these employees that went on these trips, or were they people that were selling to clients? Who were the people that would go on the trips?

Ms. MCPHEARSON. They were employees. They were executives and also brokers who would have sold Blue Cross products who were invited on these trips.

Chairman NUNN. Is this a normal custom of insurance companies?

Ms. MCPHEARSON. I think that it is a normal practice, but I do not think that the costs are normal. I do not see people going to Ireland and Portugal. I think, generally, they do tend to stay in the United States.

Chairman NUNN. What about the club expenses and the initiation fee at country clubs and the golf expenses? Is that a normal entertainment expense of businesses?

Ms. MCPHEARSON. We were told or it was argued that playing golf was certainly a business expense, and we recognize that. But to the point of charging golf balls and greens' fees and sweaters to the extent of $44,000, like was done at Avenel, we consider that a little too much.

Chairman NUNN. The thing that stands out here as far as I see, and maybe you will agree with this and maybe not, is the fact that all of this was going on—these excesses were going on while the company was really losing its financial condition.

Ms. MCPHEARSON. That is true. And at the same time——

Chairman NUNN. And while the policyholders were paying increased premiums at a very substantial rate very year?

Ms. MCPHEARSON. That is correct.

Mr. BUCKLEY. And also, I might add, Senator, as the plan lowered the benefits to its subscribers, it is not just a matter of premium income. They are also taking away certain benefits from the insured.

Chairman NUNN. How about hotel bills? Did you have any excessive hotel bills?

Ms. MCPHEARSON. Yes, we did, and that was quite enlightening. We found several costs that were just ridiculous.

Mr. Gamble stayed two separate times at a resort in Barbados. One, he requested a junior suite overlooking the water that cost the plan $891 a night. He also stayed at the same resort for $450 a night. I guess he was making up for cost there.

Mr. Kestel stayed at a resort in Arizona. That cost the plan $635 a night, and this was not unusual. We found quite a few examples of this.

Chairman NUNN. Let me just ask one final question. We have other witnesses. Let me turn to Senator Roth. How would you summarize who was at fault? Obviously, what we have had here is a company that is struggling to maintain its financial solvency. If they can make it, we all hope they do, but they are on the ragged edge, if not already below the line.

You have also got premiums going up and benefits going down. The combination of all of this indicates that the question seems to be who is at fault. Who is at fault here?

Mr. SOPKO. Senator, as we have seen with the other plans, there is a lot of blame to go around. I think, primarily, at first blame falls on senior management. Management spent the money. Management knew or should have known what was going on. Management took these exorditant trips and enjoyed this extravagant lifestyle. They also started the subsidiary explosion in the mid-1980's. There definitely is blame for the board of trustees, and it may be equal to management's culpability, because the board has a fiduciary duty to the policyholders. The board is supposed to be there to watch out for management excesses. The board totally abdicated their responsibility.

The third area of blame rests with the regulators. In this case, I think there is less blame for the regulators, because, first of all, D.C. had really no authority to get in there. As for both Maryland

and Virginia, their primary responsibility is to their subscribers, and I think they did a good job in looking out for their subscribers, but they also had problem domestic plans during the mid-1980's. So, if they are going to devote their resources to their problem plans, D.C. is an afterthought, to some extent.

Lastly, the National Association deserves a lot of blame. This was a member plan in good standing throughout this whole period of time, even though there was serious problems. I think the most serious complaint with the National Association. Is that they knew but they did not tell anybody about the problems. Again, the regulators were left in the dark as to what is going on.

Chairman NUNN. Senator Roth?

Senator ROTH. Thank you, Mr. Chairman.

First, I would like to congratulate the staff for a job very well done.

I have to say that I do have some concern as to whether or not the regulators discharged their job as would appear appropriate to me.

Let me ask you this. What was the breakdown of policyholders? What percentage were Virginians? What percentage was Maryland? What percentage was D.C.?

Mr. BUCKLEY. I will take a swing at that, Senator. The District of Columbia subscriber base is basically, if I recall the figures, 48 percent, and then Northern Virginia coming in second with about 30, I think, and then the remainder in Maryland.

Senator ROTH. So, 30 percent, how many policyholders would that be roughly?

Mr. BUCKLEY. Well, approximately, 300,000 people—because the total is 1.1 million.

Senator ROTH. Which, would you agree, is a fairly sizeable number?

Mr. BUCKLEY. Yes, sir. Sure.

Senator ROTH. We all understand, of course, that D.C. did not have jurisdiction under the law, is that correct, until it was changed by the action of this Subcommittee a year or so ago. But D.C.—rather, Maryland and Virginia did have jurisdiction; is that correct?

Mr. SOPKO. Over the business in their respective States. But both Maryland and Virginia were hamstrung. Since the most they could do is lift the license to do business in their State, they had no ability because they were not the domicile State.

Senator ROTH. Is not that a pretty serious action to lift that license on those 300,000 and 400,000?

Mr. SOPKO. That is correct, Senator.

Senator ROTH. As I understand your statement, in 1992, the Virginia regulator has taken some pretty tough steps. Could he not have done that prior to that period?

Mr. BUCKLEY. Senator, this plan was reviewed by the Maryland commissioner in 1987, and they waited 4 years.

Senator ROTH. Could I just ask the question: Did he not have the same authority, the Virginia regulator, the years before, substantially, as far as you know?

Mr. SOPKO. He would have. Yes, Senator, he would have. But what they did was they alternated every 4 years on actually reviewing what happened. So it was Virginia's turn, I believe, in——

Senator ROTH. See, what bothers me is that these regulators who had the authority, it seems to me, have some real clout, because they eliminate that license, and they lose the 300,000 or 400,000 policy holders. That is a devastating blow to an organization already in trouble, is it not?

Mr. SOPKO. That is correct, Senator.

Senator ROTH. So the only addendum I would add to what you said in your statement is that it seemed to me that there was a lack of aggressive action on the part of the regulators in both Maryland and Virginia. And to be candid, I do not think it is adequate for them to say, "Well, we are busy with other problems," when they have 300,000 or 400,000 policyholders at stake.

Mr. SOPKO. Senator, I do not mean to speak for the regulators. You will have a regulators panel coming right after us who may best explain that.

Senator ROTH. I realize that. We were apportioning blame, and all I am saying is that, while it is true that D.C. was exempted, the other two States did have a responsibility. Admittedly, they divided the responsibility, as I understand it, one auditing and then the other.

But I have to say, in all candor, I see a lack of aggressive action. Now, if they didn't have adequate personnel to do this, did they seek additional personnel?

My concern is that 300,000 or 400,000 policyholders in Virginia and, what, 200,000 or 300,000 in Maryland were at risk, and as they have shown in 1992, the commissioner is able to take some pretty tough action, if he so chooses.

I would just add that as addendum. I agree with your basic statement and compliment you on the work that you have done.

Chairman NUNN. Thank you, Senator Roth.

Let me thank all of you for your hard work. In addition to David and John and Grace who testified, I want to thank Andrea and Gene, John, Hal, Scott and Larry—Andrea Kamargo, Gene Richardson, John Forbes, Hal Lippman, Scott Newton and Larry Sullivan—who were a great help to us on this. We appreciate your help very much.

We will call our next panel. Our next witnesses today are Robert Willis, the Superintendent of Insurance for the District of Columbia, and Steven Foster, the Commissioner of Insurance for the Commonwealth of Virginia. Mr. Foster is also the President of the National Association of Insurance Commissioners. We welcome both of you here today, and we look forward to hearing the regulators' perspective on Blue Cross/Blue Shield of the National Capital Area.

We swear in all of the witnesses before our Subcommittee. I know that Commissioner Willis has testified before. We will ask you to hold up your right hand. Do you solemnly swear to tell the truth, the whole truth, so help you God?

Mr. FOSTER. I do.

Mr. WILLIS. I do.

Chairman NUNN. Thank you.

Mr. Willis, we will ask you to lead off today, if you would, and then we will have some questions for both of you after you have given your statements.

TESTIMONY OF ROBERT M. WILLIS,[1] SUPERINTENDENT OF INSURANCE FOR THE DISTRICT OF COLUMBIA

Mr. WILLIS. Mr. Chairman and members of the Permanent Subcommittee on Investigations, I am Robert Willis, Superintendent of Insurance for the District of Columbia. I want to thank you for the opportunity to appear before you today to further assist your investigation of the Blue Cross and Blue Shield organizations.

As you are aware since my last testimony before this Subcommittee, July 2, 1992, a number of events have transpired raising public and regulatory concerns about the financial condition of the Blue Cross and Blue Shield of the National Capital Area.

During the course of my testimony, I will refer to this entity, Group Hospitalization and Medical Services, Inc., as GHMSI. A copy of my previous testimony is attached.[1]

In my previous testimony, I described specific regulatory concerns the District of Columbia had regarding its limited ability to adequately regulate the financial condition of GHMSI. The inability to review transactions between GHMSI and its subsidiaries and affiliates was raised as a major concern then and is now the primary focus of the company's financial survival.

Mr. Chairman, I want to personally thank you for immediately recognizing the lack of authority of the District of Columbia that it had over GHMSI. Your July 29, 1992 introduction of Senate Bill 3092 amended Chapter 698 of Public Law 395, as amended, to correct oversights not foreseen in the 1939 charter granted to GHMSI.

I have in my testimony some comments from your floor statement. I will just move on.

Prior to the passage of this new law, Mr. Chairman and members of the Subcommittee, GHMSI was not regulated as other insurance companies are regulated in the District of Columbia. All other insurance companies have a State of domicile which is primarily responsible for the regulation of the company and its financial solvency.

Although an insurance company can seek admission to do business in other States, the licensure in foreign jurisdiction subjects the company to the regulatory authorities of the other States. On this basis, GHMSI was admitted to do business in Maryland and in Virginia and was subject to the laws and regulations of those jurisdictions.

Mr. Chairman, I welcome the new regulatory responsibilities granted by Congress when your legislation became law on October 5, 1992. However, later in this testimony, I will comment on the additional steps necessary to complete the District's regulatory authority over GHMSI.

---

[1] The prepared statement of Mr. Willis appears on page 224.

[1] Hearings before the Permanent Subcommittee on Investigations, "Efforts to Combat Fraud and Abuse in The Insurance Industry, Part VI, July 2, 1992," page 224, for referenced testimony.

From the time this Subcommittee started its investigations in July of 1992, there has been a significant decline in the company's financial condition. At the same time, GHMSI subscribers and providers have had mounting concerns about the financial integrity of the company in terms of its continuing ability to provide services and meet its contractual obligations.

Apart from subscribers and providers and who are more directly affected, there is warranted public concern for the adequacy of the regulation of Blue Cross and Blue Shield entities.

In the case of GHMSI, the more visible focus has been on the unbridled diversification strategy, which has resulted in excess of $100 million of losses, and, again, gross mismanagement in the absence of effective management and internal controls.

However, there is a broader public concern here, and that is that GHMSI subscriber rates were used to support a proliferation of businesses, which did not lower cost, but, in fact, lost money.

The two concerns that I think are central are, one, how did this happen and, two, what should be done to avoid these results in the future. As to the first question, I will leave that to the offices of the GHMSI management to explain later during the course of these hearings.

Now, as to the future, it is important to recognize at the outset that GHMSI's problems were both managerial and financial. Therefore, a singular financial remedy does not provide assurance that these results would be avoided in the future.

My testimony today will focus on the regulatory steps the District of Columbia has taken to avoid these results in the future, the regulatory changes I think are necessary to adequately regulate Blue Cross and Blue Shield entities, and the additional legislative steps necessary to complete the District's regulatory authority over GHMSI.

I will also briefly provide a general assessment of the company's financial picture and my views on the proposed affiliation between GHMSI and the Virginia Blue Cross and Blue Shield.

Now, as to the regulatory steps taken by the District of Columbia, I think fundamental to the exercise of any regulatory authority is understanding where a company is, where it plans to be in the future, and how it will achieve stated objectives.

On November 10, 1992, I required GHMSI to provide me a plan of operation demonstrating its plan results over the next 5 years. A few of the specific concerns were as follows: a projection of subscriber rates, reserves, and surplus; the effectiveness of management and internal controls; a detailed business strategy demonstrating the value to the subscriber to keep or sell subsidiary investments.

In the event of an affiliation with the Virginia Blue Cross/Blue Shield, I wanted to know the foreseeable impact on subscribers, the provider community here in the District of Columbia, and, of course, 4,200 jobs here in the District.

I received this report on January 4th of this year, and with the assistance of my counsel and financial consultants, we are in the process of evaluating this report. My goal is to develop from this data a baseline from which plans and results can be measured and

accountability directed. This baseline will also serve as a basis for determining the benefit of any affiliation to the GHMSI subscriber.

We have also required GHMSI to become licensed as a domestic insurance company in the District and to submit its rates and forms for review. The current management has been responsive to these instructions and data request.

My next major step was to engage the legal services of the law firm of Mitchell, Williams, Selig, Gates & Woodyard to advise me on a number of regulatory issues and to assist my review of the sale of subsidiary investments, as well as other matters affecting GHMSI's financial condition, but will also assist my efforts in drafting appropriate legislation to fully implement the congressional authority to regulator GHMSI.

As you may know, Mr. Chairman, Mitchell Williams is regarded as a premiere law firm in the field of insurance regulatory matters, including rehabilitation or liquidation of failed companies where necessary.

Ark Monroe, the former Commissioner of the State of Arkansas, is the lead counsel who is assisting me in these matters.

As you can well imagine, the numerical and statistical presentation of GHMSI's 1992 results, the 1993 plans, and required plan of operation is a huge task. Therefore, I have engaged the public accounting firm of Ernst & Young to assist my evaluation in the following areas: first, the reasonableness of financial projections and business assumptions contained in the plan of operation; GHMSI's current and projected financial condition; and the management parameters on a going-forward basis necessary to monitor these results; again, the adequacy of management internal control systems that new management has put in place; and, lastly, the financial exposure of future losses and contingent liabilities resulting from the sale or termination of subsidiary investments or other third-party contracts.

Although I have not received an affiliation proposal, the accounting firm of Ernst & Young will provide an in-depth analysis of the transaction and quantify the foreseeable impact on the Washington metropolitan area marketplace.

Now, I think that there are more regulatory changes necessary to regulate the Blue Cross and Blue Shield entity. So I have got four points that I will raise here today. These lie more broadly to the Blue Cross and Blue Shield entities and, certainly, would apply to GHMSI.

The first is that the Blue Cross and Blue Shield entities should be required to provide standardized management reports to assist the regulatory review of a company's financial condition.

Although reports demonstrating subscriber service standards and other financial conditions are routinely provided to the National Blue Cross and Blue Shield organization, this data is not required to be provided to State regulators.

My understanding is that the Blue Cross and Blue Shield association has in place systems to monitor an affiliate's operation results, and, in fact, this data was used to point out impending financial problems to the prior GHMSI management, but apparently was disregarded.

The subsequent results beg the question whether the association acted appropriately in not insisting that its service standards and financially based operating standards be strictly adhered to at that point in time.

The second recommendation is that it should be mandatory that Blue Cross and Blue Shield entities obtain prior regulatory approval from the domestic regulator before any investment of subscriber surplus, either in health service plans or in nonhealth insurance subsidiaries or affiliates, or with respect to third-party transactions, which would materially impact the financial condition of the company.

This requirement would place the burden on the Blue Cross and Blue Shield entities to demonstrate the benefit of the investment to the subscriber. I also think that it would be appropriate to determine if the franchise license agreement between the Blue Cross and Blue Shield association and its Blue Cross and Blue Shield entities should be restructured to obtain association approval prior to requesting the regulatory approval of such transactions.

The third recommendation, were the Blue Cross and Blue Shield entities, such as GHMSI, engaged in interstate subscriber contract business, and this is based on the geographical area that is a part of the National franchise operation, I believe that premises must be given to the solvency standards established by the domestic regulator to avoid the financial management of the company being dictated by foreign jurisdictions.

In those instances where a foreign jurisdiction require solvency standards greater than the domestic State, the insurance rates charged in the foreign jurisdiction should reflect the additional reserve requirement.

Now, in the case of GHMSI, there are three separate solvency standards being applied under State law. The District of Columbia requires life and health companies to maintain $1.5 million in surplus. My understanding is that Maryland requires a minimum of $75,000 of surplus or a maximum reserve equal to 2 months of claims and operating expenses. In Virginia, a minimum contingency reserve is required, which shall not exceed 45 days of the anticipated operating expenses and incur claims expense, et cetera, and it applies to nonstock corporations. Thus, you can see the wide variance in solvency requirements.

I think it is important to recognize that, while the District standard is based on surplus, the Virginia and Maryland standards are based on a reserve calculation. As such, it begs the question whether the rates for insurance should reflect these charges.

This recommended solvency standard approach would ensure adequate financial reserves are being maintained to meet the particular requirements of State laws uniquely structured to protect subscribers in foreign jurisdictions. Any other approach could result in an interstate Blue Cross and Blue Shield entity being managed to meet the extraterritorial requirements of another State, which may not benefit all subscribers of the interstate operation.

Resolution of this solvency issue is important to the probable future consolidation or merger of other Blue Cross and Blue Shield plans to achieve necessary operating efficiencies.

The final recommendation, I think that consideration should be given to the establishment of civil and criminal penalties against officers and directors, who by their actions or inactions abuse the public trust. Blue Cross and Blue Shield officers and directors should be held accountable to a fiduciary standard to protect subscribers and the provider interest in service standards and in maintaining a financially solvent operation.

Officers and directors should not be allowed to squander subscriber surplus or embark upon business strategies that result in—and we have gone through the substantial losses.

Chairman NUNN. Commissioner Willis, do you think those ought to be Federal statutes, or you are talking about State or, in your case, the District of Columbia?

Mr. WILLIS. Mr. Chairman, I will try and respond to your question on two levels. The District of Columbia will proceed on a legislative focus to deal with these four points that I have mentioned. So that, locally, we are going to address these concerns.

It is my hope that, as a result of these hearings, the National Association of Insurance Commissioners, that has a special committee on Blue Cross and Blue Shield plans, will take my comments and the energy that comes out of these hearings as a basis for the NAIC to draft model legislation to deal with these issues. I think that they can be dealt with at the State level. Again, these hearings provide the focus for that, and I am hoping that we will now move expeditiously.

Relative to the District of Columbia, as I just mentioned, we are unique. As you know, in the District of Columbia, we have to do a little bit more to implement the congressional authority.

My goal is that, by March of this year, we will have a draft of emergency legislation, ready to go to the District of Columbia Council for review and enactment. Within the District's unique regulatory system, this emergency law would be effective immediately for 90 days allowing an opportunity for temporary and permanent legislation to be enacted.

Now, during this interim period, the District does not have the comprehensive legislative package in place that I am referring to, and I am going to ask that GHMSI sign a consent order to serve as a short-term measure for achieving this full regulatory authority.

When the permit legislation is enacted by the Council, it will certainly need the support of this Committee in achieving swift passage of this legislation. Now, with all the cylinders in place at that point in time, it is my recommendation that Congress repeal GHMSI's Federal charter. With comprehensive legislation in place in the District, GHMSI should be treated as any other Blue Cross and Blue Shield entity under the laws of the State of domicile and certainly under the laws of the State of licensure where they are doing business in a foreign jurisdiction.

Now, I have got a few comments on GHMSI's financial condition. You have gone through it, and you have seen the pattern.

As I noted earlier, I will provide an in-depth assessment of the current financial condition. However, I really think it is important to comment on the source of the current financial problem.

We should keep in mind that a clear distinction needs to be made between the core subscriber contract business and other subsidiary operations.

Based on the 1992 financial summaries, the core health business for GHMSI earned $8.1 million; whereas, the other subsidiary investments accounted for losses of $26.8 million. At the same point in time, the problem is getting a clearer picture as to the magnitude of these losses in the future. We had many conversations with management. We have done our own consulting. It is very difficult to know the size and magnitude of these contingent losses that continue.

So we look at the financial condition of the company. Even though 1992 is a snapshot, how deep the problem is yet to be determined, and that is what we are going to do very shortly.

A recent newspaper article reported $39 million of losses in 1992. It fails to illustrate the point, however, that the core business earned approximately—and these are rough estimates—around $10 million. So that, we need to keep a focus on the point that the core business has been profitable and, based on the projections we are looking at, would remain profitable. The drain is with respect to the subsidiary investments, and, again, we don't know the extent of that.

The key risk not shown in the company's figures and projections for 1993 is whether GHMSI can maintain its profit profile in the core business, given the deteriorating results in the affiliated businesses and, of course, the mounting negative publicity.

There has also been much discussion of an affiliation strategy. I am not sure what that means yet. As a practical matter, the proposed affiliation between Virginia Blue Cross and Blue Shield and GHMSI, I think it makes sense longer term. I think that American business looks at combinations, consolidations, as a means of achieving cost. So I am not concerned with that as a business strategy. In my opinion, the management has taken the right steps to evaluate this financial strategy as an alternative.

Since there has been no representation of a proposed affiliation strategy to consider, I think it is really speculative to determine how the District would respond. I think I need to see it before I can comment on it.

Now, regardless of the form of the transaction, my primary concern is the impact on subscriber rates reserves and surplus, as well as the provider community and local jobs. On a broader plane, I would expect that the financial transaction, once finally structure, would ensure that we maintain a competitive environment in the Washington metropolitan area. That, to me, is a key ingredient that needs to be a part of the process.

In my opinion, the Blue Cross and Blue Shield must be made a key player in any affiliation strategy. I have met with representatives of the National association and expressed my views. It must be part of whatever strategy is necessary to restore GHMSI to financial health, even if this means something other than the affiliation with the Virginia Blue Cross and Blue Shield would be a consideration.

During the period that GHMSI ventured into the realm of diversification, the association was aware of the financial risk and the

deteriorating results. It seems to me that the association had a responsibility to bring these matters not only to the attention of key officers, but also to the attention of the board of directors, and did not do so.

In conclusion, I will say that, as a domestic regulator, my primary focus is the financial survival of GHMSI to protect the interest of subscribers and providers. If an affiliation with the Virginia Blue Cross and Blue Shield is shown to be the best vehicle for addressing management and financial deficiencies and does not disrupt the competitive environment in this marketplace, I will, more than likely, support such a strategy.

Since GHMSI is domiciled in the District, we should be—we being the District—the quarterback for the financial rescue effort with the firm and steadfast assistance of the Virginia and Maryland commissioners. One regulatory cannot try to solve this problem alone, and, if so, I think the whole concept of State regulation becomes meaningless.

States must work together to find common ground for the benefit of all subscribers. I believed the Congress recognized the primacy of the District's responsibility when the legislation was passed last fall.

Now, I intend to carry out these responsibilities to the best of my ability. Again, accomplishing the results for all GHMSI subscribers will require active cooperation between all regulatory officials and GHMSI management.

Since the management change was made in October 1992, I personally have found the level of cooperation and candor of GHMSI management to be prudent and responsible. While we still disagree on some points, the objective to benefit subscribers remains steadfast.

Again, I want to thank you for your support and this opportunity.

Chairman NUNN. That is since the legislation passed, you are saying. What was the attitude before the legislation passed?

Mr. WILLIS. I think it was one of gentle noes, rather than yeses.

When Mayor Kelly appointed me in August of 1991, I had occasion to be with the management at a fund-raiser and pointed out to all of them that it was my intention to regulate Blue Cross and Blue Shield and that the first step would be to include them in the District of Columbia's Life and Health Guaranty Fund. They are now a part of the fund. So we have some baseline of protection. But it was made very clear to them that I saw it as a gate and loophole in the District, and I intended to close it. That was politely handled, and we have made substantial progress since that point in time.

Chairman NUNN. Mr. Commissioner, let me ask just a couple of brief questions, and I will turn to Senator Roth, and then we will turn to our next witness, and come back and ask both of you questions.

The question of whether the D.C. Plan merges with Virginia, you alluded to that, and I want to ask Mr. Foster this at a later point. Are you precluding other purchases by your regulatory supervision from coming in and making known their interest in either purchasing or merging with Blue Cross and Blue Shield of District?

Mr. WILLIS. No, sir, not at all. I think that what I am waiting for is a presentation of the affiliation strategy, and I have communicated with management. As a part of their presentation, I would like to know what other alternatives have been looked at and why is it we are not looking at others. We have some thoughts in mind, and we will put those on the table.

Chairman NUNN. So you would welcome alternatives from your point of view?

Mr. WILLIS. Absolutely.

Chairman NUNN. Do you know whether that is the position of the current plan's management? Are they looking at other alternatives or just looking only at Virginia?

Mr. WILLIS. I have, you can appreciate, raised this point several times. I have been told that other options had been looked at; that the Virginia option at this point in time appears to be the best option. And my position is when you lay out the option, I would like to have more detail as to what other options have been considered.

Chairman NUNN. If there were people that felt that they were being precluded from expressing an interest in that, who would be the appropriate person to make that known to? You?

Mr. WILLIS. Please.

Chairman NUNN. One other question, you have heard the expenditures listed here. I don't want to get into each one of them with you. But the general scheme of expenditures—club expenses; golf expenses; City Club expenses; wining and dining; trips to California for 100 and some odd people that were on the payroll, some of them and some of them, perhaps, customers; jet airplanes first class, Concord; and so forth and so on—is this normal in the insurance business as an accepted kind of practice? Are all insurance companies spending money like this?

Mr. WILLIS. No, Senator, not to my knowledge. I think that this is a unique situation. I will not use the brush to paint all insurance companies.

My thoughts are that we are dealing here with a nonprofit entity that enjoys a unique position in the delivery of health services of this country; that in exchange for a nonprofit status and in exchange for the ability to literally carve up the Nation and allow the affiliation to occur within designated areas, there is an issue here of public trust that goes above and beyond, in my opinion, what you would normally expect from an insurance company.

These kinds of entities should carry out the public trust in a vein where the attitude and the management responsibility is to lower the cost of insurance, and these kinds of expenditures are certainly inconsistent with that public trust.

Chairman NUNN. How do you feel about what you heard here this morning in terms of those expenditures?

Mr. WILLIS. I think they are over the moon, frankly, and, if the came under the purview of regulators, would not be allowed.

As I mentioned as part of my testimony, we need to have a reporting mechanism in place that allows a regulator to take a look at how these monies are being expended, and I hope that, as a result of these hearings, these kinds of behaviors, if they are occurring elsewhere, will cease and desist.

Chairman NUNN. Do you get this kind of information about the expense accounts and travel and all of that from other insurance companies that you regulate?

Mr. WILLIS. Senator, what happens during the course of a financial examination, my chief examiner and his staff have the ability to go in and summon those records, and they do review that level of detail.

Chairman NUNN. So you have the ability to get that?

Mr. WILLIS. That is correct.

Chairman NUNN. Senator Roth, I am going to turn to Commissioner Foster here and then come back and ask questions to both, but I will be glad if you want to interject.

Senator ROTH. No. Go ahead, please.

Chairman NUNN. Commissioner Foster, we are pleased to have you this morning. I know you wear two hats. One is the Virginia hat, and the other is the president of the National Association of Insurance Commissioner's hat. We welcome you here.

Mr. FOSTER. Thank you.

Chairman NUNN. We would like to hear from both of your responsibilities as to how you view this situation now.

TESTIMONY OF STEVEN FOSTER,[1] COMMISSIONER OF INSURANCE FOR THE COMMONWEALTH OF VIRGINIA AND PRESIDENT OF THE NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

Mr. FOSTER. Thank you, Mr. Chairman and Senator Roth. Good afternoon.

I am here primarily wearing my older hat; that is, as Virginia Insurance Commissioner, which I have been now for almost 6 years.

Mr. Chairman, we welcome the attention you have given to Blue Cross and Blue Shield plans generally and the other areas you have given your attention to in regards to insurance company fraud, and we are pleased this year that your commissioner from Georgia, Tim Ryles, will be heading up our effort in that regard.

Senator Roth, we welcome your new commissioner, Commissioner Williams, to our ranks and look forward to having her active participation as well.

The NAIC, as you know, is a voluntary association of the chief regulatory officials. Bob Willis and I represent two of those 55 which come from the 50 States, the 4 U.S. territories, and the District of Columbia.

I have submitted separate testimony in my capacity as the NAIC President, which is apart from my testimony as the Virginia commissioner regarding our regulatory oversight, including the most recent examination of GHMSI.

It is my understanding your rule suggests that I summarize my testimony in about 5 minutes and then answer any questions that you may have. So I will do that and would certainly like, at the appropriate time, to offer my prepared testimony for your record.

---

[1] The prepared statement of Mr. Foster appears on page 228.

Chairman NUNN. All of that will be part of the record, your entire statements, both of you, without objection.

Mr. FOSTER. Thank you very much.

Since becoming the commissioner in Virginia, 6 years ago, we have regulated both GHMSI as a licensed foreign health services plan and our Richmond plan, and there has been no priority attention given to the domestic versus GHMSI with the exception being that we have worked with Maryland in doing a quadrennial examination. Typically, you try to perform an examination every 3 years, but most of our statutes require an examination every 5 years.

During the most recent examination, Virginia took the lead in the examination, (12-31-91 was first time we took lead). We made an offer to the other jurisdictions to participate and they elected not to participate. As I have said in my testimony, Mr. Chairman, because of our statute in Virginia, I am precluded until 30 days runs from commenting specifically on the examination results, and I hope that you and the Committee members will give deference to that.

I would be happy to answer any other questions, generally, regarding our regulatory oversight, but may not comment, under our statute, until the time tolls as to the most recent examination.

When we look at GHMSI as the examiner or the regulator in charge of the examination, I would like to make one thing clear. GHMSI has one surplus. It does not have three surpluses. I am not looking specifically to see that Virginia contracts are properly reserved for. I am not looking to see that Virginia contracts are sufficiently capitalized.

What we look for is the extent to which they are solvent. Each State, as Mr. Willis indicated, has its own level of capital. Our contingency reserve, as was described earlier, is nothing more than a surplus requirement.

Virginia has historically, perhaps unlike other States, had a more rigorous regulation as regards to solvency of health service plans. For example, our 45-day requirement roughly translates into a $45-million surplus requirement. Our responsibility as the Virginia regulator is to make sure this foreign carrier, like any other foreign insurance company, maintains Virginia's minimum required statutory surplus.

If this were a commercial health insurance company, for example, they would have a $4 million capital and surplus requirement. Now, other jurisdictions may have less. We have an obligation to make sure that any company licensed in Virginia meets Virginia's minimum threshold requirements, which certainly may be different from other States, and certainly is in many respects.

The 45-day requirement is, if you will, a floating requirement. It goes up and down, depending on the level of Blue Cross/Blue Shield's expenses, both claims and operating expenses. But that is the yardstick against which we must always measure this particular plan's ability to meet its obligations to Virginia policyholders. But we are looking at the company's total surplus, not just the surplus which would be assigned to Virginia contracts.

Keep in mind that GHMSI, like other Blue Cross/Blue Shield plans, has both at-risk business, in which they assume the risk, and

business for which is not at risk, which is typically the administrative services' only type of contracts.

Our experience with the prior management of GHMSI, frankly, has been a most difficult one. As I have described to your investigators and others, we have had difficulty in the past getting what we believe was reliable financial information from that company. It got to the point that I contacted the then-chairman, Mr. Gamble, and told him that I would no longer meet with his then-CFO and his then and current general counsel, because, frankly, we had gone through too many sessions when we were not getting straight answers, which I am pleased to say has not been my experience generally in dealing with insurance companies in Virginia, both domestic and foreign.

Whether or not we agree or disagree as to the appropriate regulatory action that is to be taken, we for the most part get cooperation and get straight answers from CFOs and others in regards to various items that they are trying to report, for example, as an asset on their annual statement.

We took early exception, back 4 years ago, to GHMSI's insistence that we allow as an asset the investment in Jamaica. We had a meeting in my office at that time, and, since that time, they have not produced the documentation we think is sufficient to allow them to treat this as an asset.

Our statute on the other hand does not tell us that we can prohibit them from making such an investment. Generally, if you look at State insurance company investment laws, there is a fair amount of discretion given to company management, particularly, as to how they invest the company surplus. We are not there to look in advance at every single investment that an insurance company makes.

Insurance statutes typically provide guidelines, limitations, and other statute and regulation that give insurance company management guidance as to what we think from a solvency standpoint is an appropriate investment strategy.

But in spite of our problems with GHMSI, it has never deterred us from regulating it in the manner we thought was appropriate. Yes, there have been problems in the past trying to understand the extent to which GHMSI was or was not subject to the District's insurance laws.

GHMSI would hire outside counsel and would make those kind of assertions. We were always skeptical, and we would communicate with the District, Mr. Willis' predecessor, and others, trying to understand the extent to which, for example, this particular plan was subject to the District's insurance holding company act.

It has been a mystery to me, frankly, what is the full breadth of the congressional preemption. It has been difficult to fully understand the extent to which Congress intended to preempt this particular Blue Cross/Blue Shield plan from the District's insurance regulation. It is a very unique dilemma that Congress poses to State regulators when this kind of preemption, if you will, is made part of a charter, and then we in Virginia and Maryland, obviously, are looking at the maintenance of that same company's license in our States.

So it has always been difficult, but it has never served to be such a roadblock that we cannot, frankly, through more intense effort get to the bottom of. This is what led to our conducting the examination during 1992 and to what is viewed to be a fairly drastic measure, a consent order that said we would look at the flow of all funds between and among GHMSI and its subsidiaries.

If I could shift to the NAIC's activities——

Chairman NUNN. Without getting into the details of your examination, which I will respect your statute on and refrain from, did you have access to all the information on the subsidiaries as you were doing your examination?

Mr. FOSTER. It was very difficult, Mr. Chairman. We finally had to have a meeting with executives of GHMSI. We were trying to determine, as we do every 3 months, if they comply with Virginia's 45-day—or roughly today—$45-million surplus requirement. We found that, in spite of the persistency of our examination staff to ask for documentation regarding some of their subsidiaries' receivables and payables, it was never produced. I think, generally, we found that the new management was more willing, both with Mr. O'Malley's coming on the scene and Mr. Giuliani's new role.

I did sense at some point in time an understanding that it was in their best interest to give us everything they had. But prior to that time, it was very, very difficult, and our requests were being ignored. Once we had this meeting, frankly, it was amazing that within 24 hours documentation was produced, because we had to threaten, among other things, to take their license in the event they would not cooperate.

Taking the license, obviously, is a very drastic action that not only affects the viability of that plan, but, to borrow Senator Roth's numbers, affects those 300,000 individuals.

In Virginia, we have a guaranty fund, as does the District. But we have tried to keep in the back of our minds the extent to which any precipitous action we take may, in fact, have an adverse effect on those contract holders, both group contract holders and individual contract holders, who may be caught in the middle. That is always a consideration a regulator has to give. But, frankly, in the end, if they are not able to maintain the requisite surplus requirement in Virginia, I have no choice but to recommend to the commission that they do two things: first, cease writing new business immediately and, second, either restore themselves to a proper financial condition, or surrender their license.

Chairman NUNN. When they surrender their license, when you give them that ultimate sanction that you have the power to do, they still are responsible for the claims of those they have already insured?

Mr. FOSTER. Well, you would then have the triggering, Senator, eventually, depending on how the receivership laws, if they were kicked in would trigger a guaranty fund stepping in at the appropriate time. So it really depends on how that would happen.

Chairman NUNN. It doesn't relieve them of their liability though?

Mr. FOSTER. That is correct. It does not relieve the company or its receivership estate from that liability. But if a domiciliary regulatory in a typical situation were to put this company in receiver-

ship, the insurance commissioner then has under his jurisdiction all of the assets of that particular insurance company; in this case, GHMSI. And those assets would be used to satisfy those policyholder obligations.

To the extent to which the assets are unable to satisfy the obligations because of a deficiency, you would then turn to the guaranty fund to make up the difference.

Chairman NUNN. Do you want to go ahead and put on your other hat here?

Mr. FOSTER. Yes. Let me summarize quickly. The NAIC has gone through a process for over 12 months to try to identify those areas that we think need the attention of all State insurance regulators.

It has often been asked why have we not adopted certain financial measures regarding Blue Cross/Blue Shield plans as we do for other companies.

I think the answer is pretty straightforward. It is that most Blue Cross/Blue Shield plans, with the exception of GHMSI and, perhaps others, operate on an intrastate basis. Most of the NAIC's activities, as the forum for regulators to work together towards providing consistency and, where appropriate, uniformity, have been in the area involving the interstate business of insurance.

I think we recognize now there is enough concern, both within the regulator ranks here at your Committee and among contract holders and the public generally, that many may believe this system is a national system.

I, for one, know it is not, and I would suggest that probably most of the people in this room know it is not, but many others out there across this country probably do think, because of the marketing of the trademark, it is a national plan with some kind of national guaranty, if you will.

This Committee will pursue its work during the course of 1993. I will not repeat some of the things that Mr. Willis just mentioned to its focus. I think there is lots that he and I can do with other commissioners to steer that Committee in a proper direction and bring forth model legislation that will help those States who, perhaps, do not have the regulatory tools that they currently need.

The NAIC can play a very valuable role in that regard in assisting the States to look at what ways to best regulate the Blue Cross plans, given the differences among the Blue Cross plans. Should we have standard financial reporting requirements, for example, a standard capital requirement? One issue that is out there is the extent to which most States do not have Blue Cross/Blue Shield plans in their guaranty funds.

In Virginia, we believe they should belong to a guaranty fund. The same, apparently, is true in the District. As one commissioner, I would encourage all states to include them. But the NAIC may want to consider the fact that unique circumstances exist in some States where it may not be appropriate to belong to a guaranty fund.

Our Richmond Blue Cross/Blue Shield Plan, for example, has to provide coverage to all comers, as does the D.C. Plan, but we still require them to belong to our guaranty fund. So we believe in Virginia, that the ultimate protector to any policyholder, whether they

be a subscriber of Blue Cross or a commercial insurance company, is guaranty fund protection.

So, with that, Mr. Chairman, I would be happy to answer any questions you or the Committee may have regarding the NAIC's activities or mine as the Virginia commissioner relative to GHMSI.

Chairman NUNN. Let me just ask a couple about your Virginia responsibilities, Mr. Foster, You have a Blue Cross/Blue Shield Plan of Virginia, correct?

Mr. FOSTER. That is correct.

Chairman NUNN. Just one in Virginia that covers the whole State?

Mr. FOSTER. Yes, sir. That resulted from a merger prior to my being the insurance commissioner, prior to 1987. I believe it was back in 1985. There was a merger between the former Roanoke-based Southwest Virginia Plan and the Richmond-based plan, what we call the Virginia Plan. So it is now one plan that serves all of Virginia with the exception of the counties and cities in the extreme northern part of Virginia.

Chairman NUNN. Are you comfortable that that plan is in sound financial condition?

Mr. FOSTER. Yes, sir.

Chairman NUNN. When is the most recent time you have examined them?

Mr. FOSTER. I think our most recent financial condition examination—I would have to check this—was within the last 2 years. But we require quarterly filings from our domestics as well as the annual financial statements, and we work very closely with the Virginia Plan

The Virginia Plan, I will say, mutualized 2 years ago and is under a different statutory surplus requirement as opposed to GHMSI.

Chairman NUNN. We certainly don't have any information that would indicate anything other than that plan is in the condition you have described, but we have gotten allegations about the Virginia Plan, and I won't get into detail on the allegations, except that we do have information that they own two jet aircraft.

Is it normal to own a couple of jets when you are really operating within one State as an insurance company?

Mr. FOSTER. Certainly, it is not normal if normal is defined to be: Do our other domestic insurance companies have airplanes? No.

My understanding is Blue Cross/Blue Shield owns some kind of leasehold interest, partial interest in one, and may, in fact, own an interest in another aircraft.

There may be a different set of circumstances here, and the Blue Cross/Blue Shield success, obviously, at negotiating with providers and the like requires them to be around the State negotiating with hospitals and doctors to get discount fees. Such is not the case, obviously, with our other domestics, where they are primarily life companies or property and casualty companies, and those other companies are writing in other States as well.

I am aware that Blue Cross/Blue Shield has used these jets. It is not something that is subject to my regulatory approval. I don't approve their purchase of a leasehold or partial leasehold, and I have

just got to accept that that is a decision that management makes that, hopefully, is in the best interest of that plan.

There obviously are commercial flights that you can take from Richmond to get to, for example, Roanoke, to get to Norfolk, to get to northern Virginia. There are no commercial flights, because I experienced this myself, getting to anyplace else in Virginia. For example, if you want to go to Bristol, you have to go through North Carolina and Tennessee first to get back up into Bristol. So I don't know the extent to which they could accomplish their same mission by using commercial aircraft and cars; that they choose to use instead their own facilities.

Chairman NUNN. Could you give us an explanation of why your office has required the D.C. Plan to fully reinsure its Virginia businesses or, rather, to reinsure the Virginia businesses at the same time, as directed, they have reserves sufficient to cover claims for 45 days?

Mr. FOSTER. We never required that.

Chairman NUNN. You have not required that?

Mr. FOSTER. No, sir. I have been at odds with the National Blue Cross/Blue Shield Plan since August. I have been asking them to, please, tell me what will happen if one of the plans that enjoys their name and trademark fails to meet this one State's requirement, that being Virginia. Their answer as of this day is, quote, "We don't know," end of quote.

After several meetings with them, they said to me: What would it take to, hopefully, guarantee you will not take steps to prevent our GHMSI—which carries their trademark—from selling new contracts in Virginia? We discussed as two possibilities their fully reinsuring those Virginia contracts and putting in additional capital. They are apparently very concerned that we may take appropriate action on the day that that plan, which has their name and trademark, fails to meet our requirement, and they are exactly right. We intend to.

We never specifically required reinsuring of them. That was suggested as one of two possibilities, and when they came back with both of those, obviously, we welcomed both of those.

GHMSI has one surplus, but Virginia has a surplus requirement that, obviously, is substantially above the other two jurisdictions, and when I take my oath of office in Richmond, I need to make sure that this licensed foreign insurer that Congress preempted from the District's regulation, meets our licensure requirements. That is my duty, and I intend to fulfill that.

Certainly, the fact that the National association offered to put in $15 million, and we said to them if the terms and conditions of that surplus are satisfactory, we will count that as equity.

Likewise, if you want some buffer against Virginia taking appropriate action to restrict your writing new contracts, then reinsuring the book of business in Virginia is a possibility.

Chairman NUNN. Commissioner Foster, do you believe that the problems uncovered in the West Virginia Plan, the Maryland Plan, and the D.C. Plan pervasive throughout the insurance industry, let's say, in the nonprofits, first of all, and in the profits, or are these abberations? What is your experience?

Mr. FOSTER. Senator, I cannot describe them as being abberations, because I have not, obviously, conducted an analysis of each one of these plans. Obviously, the three you have picked, West Virginia, the District, and what I read about Maryland, may, in fact, be, in some respects, the more extreme.

There certainly is grave concern on the part of all regulators if management of a company and its board of directors is, in some respects, abdicating its fiduciary responsibility to policyholders.

We regulators are called upon frequently to explain how our regulatory oversight extends to the management of the company, and to what extent under our statutory and regulatory scheme do we give, frankly, leeway to management to run the company? Until such time as regulators are charged with a task of running the company or something close to that, then our job is to examine periodically the extent to which any insurance company has, in fact, complied with our laws, including investment laws, asset valuation laws or an insurance holding company requirement. And there is lots of evidence with regards to GHMSI that they have for the most part, ignored our laws and havechosen not to make the requisite filings.

Chairman NUNN. The National association has a unique relationship with the 73 Blue Cross/Blue Shield Plans that it franchises, but I am told they do not keep the insurance commissioners informed of the restrictions they place on any kind of troubled plans. Is that your understanding?

Mr. FOSTER. Let me just say, I have never been informed of such restrictions. Now, if they are informing other commissioners, I obviously cannot speak to that.

Chairman NUNN. Does the NAIC have any kind of position on that? Are you advocating or are you requesting that the National association begin to be more cooperative with your group?

Mr. FOSTER. Yes, sir. One of the charges that we are suggesting be given to our committee—and I say suggesting, because our executive committee approves the charges in about 2 weeks here in Washington—is to look at the appropriate oversight role of the National Blue Cross/Blue Shield Association.

I have been told in the past by Blue Cross/Blue Shield executives that I should not have as much concern as I would, perhaps, have otherwise about a company's solvency, because the National Blue Cross/Blue Shield Association has certain requirements. So take comfort, Commissioner; that is your first-line defense.

As I dug more and more and asked questions through one of our Blue Cross/Blue Shield Plans, I would say: Can you find out for me? Leading up to my most recent understanding that the National Blues, in some respects, proudly proclaims that they now have effective solvency standards, you ask them what they are, and they say a surplus of zero, and they are serious.

Now, here you have a National association that has said: in the past they have standards; they are policing their own members; if you don't stand up to their standards or don't comply with those, you will somehow lose your name and trademark. For them to now suggest they have made great progress and the standard now stands at zero, I don't think any State shall allow any Blue Cross/

Blue Shield Plan—I am speaking as the Virginia Commissioner——

Chairman NUNN. Right.

Mr. FOSTER [continuing]. To operate if the company doesn't have a positive net worth. I just think that is fundamental.

The Virginia State Corporation Commission, who are my three bosses, and I went to our legislature 4 years ago and said, "We don't believe a 30-day reserve requirement is high enough." These Blue Cross/Blue Shield Plans will tell you they are subject to 3-year cycles. For the most part, they are a monoline company. They are writing accident and sickness insurance, and we saw great swings, quarter to quarter, at the extent to which our Blue Cross Plans could meet a 30-day requirement.

We went to our legislature and said, "It is not enough. Make it 45 days." We asked for 60 days, and it was eventually given to us to be 45 days. So, to suggest now that zero is appropriate, frankly, I find it just really hard to believe.

Chairman NUNN. Does the NAIC have any position about the formation of subsidiaries operating under a nonprofit like Blue Cross/Blue Shield? Does the National association have a policy on that and the regulatory aspects of that?

Mr. FOSTER. We have an Insurance Holding Company Act model, which we require as part of our new financial solvency standards. We now require all States to be accredited, to be members of the NAIC in regards to under what circumstance will Virginia defer to a foreign jurisdiction, a foreign State. We use the term "foreign" to mean other than Virginia.

One of those requirements is that you have to have on your statutes an Insurance Holding Company Act substantially similar to the most recently revised NAIC Model Act. One of the things that I have requested our staff to do this year is to look to see the extent to which we need to make it clear that Blue Cross/Blue Shield Plans should have to comply with the Insurance Holding Company Act.

In Virginia, we have health service plans subject to a more rigorous Holding Company Act. Our legislature looked at this about 4 years ago and decided Blue Cross/Blue Shield Plans were unique, and, if anything, there should be a higher test as to transactions between and among Blue Cross/Blue Shield Plans and affiliates.

The Richmond Plan is not subject to that more rigorous Holding Company Act, because they chose to mutualize 2 years ago, and as a result of that they are once again, subject to the more general Insurance Holding Company Act.

So, yes, the NAIC recognizes that we need to make sure each State has a holding company act, and one way to make sure is to consider enforcing it through our financial solvency standards. That must go to a special committee and must be approved by the membership, but there is a requirement currently that every State which wants to become accredited—and we expect all States to be—has to have an Insurance Holding Company Act on their books.

Chairman NUNN. Superintendent Willis suggested, and I would like to get your view on this, Commissioner, that there be consideration given to establishing similar and criminal penalties applica-

ble to insurance companies' officers and directors, who by their actions or inactions violate the public trust. What do you think of that? Do you think the criminal laws are sufficient now? Do you think we need to take a look at further criminal laws, and, if so, should it be Federal or State?

Mr. FOSTER. Sir, you know the NAIC's interest in trying to get whatever help the Federal Government can offer to us in the arena of insurance company fraud. I have not spent a lot of time researching the issue. I just saw Commissioner Willis' testimony late yesterday.

I think it certainly bears some study. I think we have to do all we can do as regulators, working jointly with our legislators, to stiffen, to the extent appropriate, the penalties in the event some of these things are uncovered.

I am distressed somewhat at companies we have had in receivership, things I have heard both today and prior to today as to GHMSI's board of directors. There seems to be among some insurance companies—and I want to emphasize that, amongst some—a general willingness to let management run the company, and the board, if you will, convenes every few months and approves it after the fact. So that, if we can get boards of directors to pay more attention to what is going on in their companies, then I would suggest one way to do that may be to stiffen those penalties.

Chairman NUNN. You heard about the salaries and the expenses this morning. Without going into detail and asking you about each of them, which I won't do, what was your general impression of what you heard from the staff report in terms of the expenditures of this particular company compared to what you know to be the practice of others?

Mr. FOSTER. Certainly, when I learned during the course of our examination—again, I can't reveal the examination findings, but when we learned the level of salaries of the top management, and probably of more concern, on top of those salaries, various bonuses given to GHMSI officials, I was dismayed. I was dismayed at how a plan could lose money, but turn around and give the chief financial officer a bonus.

I asked for a copy of the standards for providing these bonuses. There were no standards. At least if there were, they have yet to be produced. So, yes, the level of compensation and, particularly, bonuses which are given with the blatent disregard for performance—there are no performance standards, apparently—are troubling to any regulator.

On the other hand, I would have to say that we don't give prior approval to the salary level of insurance company management.

Chairman NUNN. What about the expenses we heard, Concord, country club memberships, and all of that? Is that standard procedure?

Mr. FOSTER. I do not believe so, and, again, I am speaking from my experience dealing with our domestics and other companies I come into contact with.

I don't know why GHMSI took the Concord so much. I don't know why they chose this global strategy that, apparently, was not knit together by any reasonable strategy. They have their reasons, and I am sure they will probably offer some of those tomorrow.

But the extent of these expenses has been enlightening to us, frankly. Under the consent order, some of the things we were asked to comment on or approve, we turned down; we turned down trips and travel for marketing people to convene in certain resorts and places to have marketing meetings. We said, "Listen, this is a difficult time for this plan, and we don't think these expenses can be justified."

So, certainly, they are of concern. Certainly, every insurance company has an obligation, both to its policyholders and, if it is a stock company, to its stockholders, to spend its funds wisely, and I am very concerned the extent to which GHMSI or any Blue Cross holding company board views the Blue Cross Plan as what I refer to as a cash cow. It is a cash cow with lots of premium flowing in, and from that you could invest in all of these other investments.

They would have been far better off, obviously, investing in things with perhaps a little bit lower returns or expected returns, but things that certainly would have some value down the road.

Chairman NUNN. Commissioner Foster, with your NAIC hat on, do you have any suggestions for the legislation at the Federal level? Is this something the Federal Government needs to get more involved in because of the overlap between States, or do you believe that the NAIC and the various State regulators are up to the task of handling these challenges? By these, I mean Blue Cross/Blue Shield and this type of organization in general.

Mr. FOSTER. Commissioner, I think the States are up to the task, with the assistance of the NAIC and the role the NAIC plays as a vehicle which we can develop and adopt and, through our accreditation program in may respects, require States to adopt these more rigorous measures.

I think we are coming to realize that, although Blue Cross/Blue Shield Plan are not interstate in nature and, thus, there has not been the same attention in the past for uniformity a certain commonality exists among these plans. On top of that, the fact that most subscribers think that when they buy a Blue Cross/Blue Shield policy, it carries with it, perhaps, something more than just that specific Blue Cross/Blue Shield Plan's surplus and financial condition.

I am not saying they should believe that, but I do believe most of them feel that way. So I think the NAIC and the States can do it. States up to now have taken action. We have carved a particular regulatory scheme for GHMSI in Virginia without the benefit of model acts to try to deal with the preemption of the District's regulation placed upon all of us by the Congress some several decades ago.

States don't wait for model acts. We have taken action in Virginia. As to this particular plan, we have adopted a more rigorous Holding Company Act, but even with the adoption of those acts, we can't ensure daily compliance by the companies in Virginia with our laws. We do review annual statements. The one they filed back last March was an abomination. We had to suggest they refile it, because it had been filled out improperly.

This is a continuing pattern on the part of GHMSI either because they don't know how or, perhaps worse, don't take the time

or, perhaps even worse than that, are trying in some way not to characterize accurately the financial condition of the company.

I have never had a company more difficult than GHMSI in trying to get straight factual data regarding the financial condition of that particular company.

Chairman NUNN. In other words, they have been the worst?

Mr. FOSTER. No question. In fact, I have never told any other CEO that I would not meet with that company's CFO and general counsel. I told that to this CEO.

Chairman NUNN. When was that?

Mr. FOSTER. About 3 years ago. The meetings were not productive. We were not getting straight answers. I was getting frustrated. My blood pressure was going up, and I said send me somebody else to talk to.

In the end, Mr. Gamble himself finally came to my office to see if he could help straighten things out a little bit, because his lieutenants, prior to that, just simply were not dealing with us in a straightforward manner.

Chairman NUNN. Senator Roth.

Senator ROTH. Thank you, Mr. Chairman.

Mr. Foster, let me ask you, prior to that meeting with Mr. Gamble, had your organization audited the accounts of this Blue Cross?

Chairman NUNN. We had worked in conjunction with Maryland on doing a joint examination prior to that. They are joint examinations. It is not a matter of Virginia handing off to Maryland and vice versa. They are examinations where one State takes the lead, but the other State provides examiners on the examination team.

Senator ROTH. So such joint examinations had actually been made prior?

Mr. FOSTER. That is correct. Plus, they had filed quarterly statements with us and, eventually, I believe, monthly statements to allow us to do, if you will, desk audits in Richmond. So we are not sitting in Richmond waiting for 3 or 4 years to roll around. Keep in mind, we are looking at the annual statements they filed, and, of course, these are sworn-to statements, and you assume that they are truthful. You always ask questions to make sure that it is an accurate representation of the company's financial condition.

But we had been involved in prior on-site examinations, and we were doing desk audits based on quarterly annual statement filings and, more recently, monthly filings.

Senator ROTH. Did those audits by your organization indicate this company was in trouble?

Mr. FOSTER. Well, going back about 4 or 5 years ago, under our statute, if they could allege that they were an agency plan, which meant that they were guaranteed by the providers, doctors, and hospitals, then our more rigorous 45-day requirement and guaranty fund participation was not applicable.

They tried to make that arguments back then. They said that they were an agency plan. We said, "Show us the documentation." After they were unable to show us the documentation, we said, "OK, if you are not an agency plan"—and the theory there is if doctors and hospitals are guaranteeing these contracts, then you don't have as high a surplus requirement, because they are being

guaranteed by doctors and hospitals, people that have, obviously, their own corporate net worth, then you must be a health services plan.

When we learned they were not an agency plan, we required them to meet the 45-day requirement, and, obviously, we were very concerned at that point, because their surplus, I think, frankly, was probably below $10 million at one time. That is when the Blue Cross/Blue Shield Plan of Washington understood that our statute would provide for them to be able to appraise their building and to get the full appraised value for that building towards their net worth. If you will, there was a loophole in our statute. We had to acknowledge that the loophole existed. They were able to admit the full value of the building.

We quickly went to our State legislature and said, "This loophole is not appropriate. It should not be there," and that loophole was closed, and no other insurers have enjoyed the benefit of that loophole.

Senator ROTH. But it was that reevaluation of the value of the building that really postponed the day of reckoning?

Mr. FOSTER. No question. It makes no sense to permit any company to value their building at market value. Our statute at that time said that, as long as the appraisal was satisfactory to the State Corporation Commission, they could admit it.

So our only way to refuse it was to say the appraisal was not, in fact, satisfactory, and to ensure that we were involved in the actual selection of the appraisal company.

But it is no question, Senator, their being able to admit the full market value of the building is what kept them from being under the 45-day requirement.

Senator ROTH. Now, as I understand it, you are requiring them to revalue that building at what cost?

Mr. FOSTER. Well, we just asked that they have a new appraisal done, and the appraised value dropped, as I recall, from $90 million to $68 million, in a 2-year period. Again, I guess that was primarily a result of the overall deflated value of real estate in the District of Columbia.

We were concerned. They didn't volunteer it. We said we want to see a more recent appraisal, and once we saw the more recent appraisal, we non-admitted the difference between the $90 million and the $68 million and said, "All you can admit is $68 million." So $22 million of surplus, if you will, disappeared.

Senator ROTH. I am not quite clear how that corrects the loophole.

Originally, you had to place it at cost.

Mr. FOSTER. That is correct.

Senator ROTH. Then, because of this loophole in Virginia law, it went up to an additional $80 million; is that correct?

Mr. FOSTER. That is correct.

Senator ROTH. Then you lowered, but only to 60. If you corrected the loophole, why would it not go at cost?

Mr. FOSTER. I am sorry. Let me clarify that. The extent to which we were able to close the loophole did not affect their grandfathered status. Under most investment laws, whatever method you value an asset, you are allowed to maintain it under that same

methodology, if you will. If a company buys what we call a Category One asset and it later becomes Category Two, they may carry it as a Category One for as long as they own that asset.

There is no question, Senator, that their finding that loophole, if you will, permitted them then and since then to include, in the calculation of their net worth, an amount equal to the fair market value of the building, which certainly, from any liquidity test, is not a very liquid asset.

Senator ROTH. So the loophole, really, has not been corrected?

Mr. FOSTER. The loophole has been closed in regards to any other insurer. It did not affect GHMSI's use of the benefit and their continued use of it. That is correct.

Senator ROTH. Will they be required to reevaluate that building on a regular basis?

Mr. FOSTER. That certainly is within our discretion and is something we believe should be constantly looked at.

Senator ROTH. What is the reserve requirement for Virginia Blue Cross Plan? Is it different from D.C.?

Mr. FOSTER. Let me clarify the definition of reserve when I answer the question. Reserves are commonly what we think of as liabilities. That is the amount that insurance companies sets up to underscore the claims it must pay out.

We confuse things a little bit when we talk about a contingency reserve. It really is the same thing as net worth or surplus. So, if we are talking about surplus, which I assume is what your question is driving at, Richmond by being a mutual has to maintain a statutory capital and surplus of $4 million, as do other mutual insurance companies.

Senator ROTH. Versus 45 days?

Mr. FOSTER. That is correct.

Senator ROTH. What would that equate in dollars?

Mr. FOSTER. I can provide that to you. I don't have it in front of me.

Senator ROTH. Can you give me a rough estimate?

Mr. FOSTER. Well, let's just say it would be somewhat akin to the $45 million that GHMSI has to maintain, but I would be happy to provide the specific number to you after this hearing. I just wouldn't want to venture what it would be without being able to check. It would be substantially higher, no question.

Senator ROTH. Why is there such a great difference, a great disparity?

Mr. FOSTER. Because they are a mutual insurance company. Our Blue Cross/Blue Shield Plan still maintain the name and trademark of Blue Cross/Blue Shield. They are one of—I believe there are 12 or 14 Blue Cross/Blue Shield Plans who give up being health service plans and become mutual insurance companies, which they may do. Our law was amended by our legislature to specifically permit the Blue Cross/Blue Shield Plan to mutualize.

Now, understand we don't wait until the company hits $4 million to take what we think is appropriate regulatory action. There have been occasions in Virginia when we have taken companies into receivership who were subject to that same $4 million, but the company had a reported net worth of over $100 million. So we have the right far above that $4 million threshold to say we believe a compa-

ny's continued operation is financially hazardous to contract holders and other creditors. So we can take action before they hit the $4 million.

Senator ROTH. Let me ask you the question differently. If you were drafting new requirements, would you make this distinction?

Mr. FOSTER. Senator, all I can say is that, in Virginia, if you are a health service plan, we have always had a more rigorous requirement for health service plans. That pre-dates me.

Senator ROTH. The question I am asking is: Does it substantively make sense in your judgment?

Mr. FOSTER. The General Assembly of Virginia considered it when they allowed the Blue Cross/Blue Shield Plan to mutualize.

Senator ROTH. I am asking you, your recommendation, your opinion, your judgment.

Mr. FOSTER. I am not bothered by the fact that the Richmond Plan, which I think has roughly $450 million in surplus—I have not seen their annual statement filing as of 12/31/92, but they had roughly that back in 1992. Knowing the other regulatory tools we have to take appropriate action, I am not bothered by one plan, which is a mutual, having as a minimum threshold $4 million, and another plan with a different corporate structure having a 45-day reserve requirement.

Senator ROTH. My only comment is that I think it would be very difficult for a policyholder to understand this difference.

Mr. FOSTER. Well, sir, if I could respond to that, too, a policyholder in Virginia has one or the other. In northern Virginia, because of the trademark and name, you may only buy a GHMSI Blue Cross/Blue Shield policy. South of a given geographic line in Virginia, you can only buy a contract from the Richmond Plan.

What I think makes them both, if you will, more the same is, regardless of what happens, the Virginia public, whether they be northern Virginia or the rest of Virginia, are protected by our statutory guaranty fund. If we did not have a guaranty fund in Virginia, then I may answer your question differently. But, in that respects, the policyholders of each of those two companies have the same protection.

Senator ROTH. Let me have just one further question, Mr. Chairman. Now, in your prepared testimony as Commissioner of Insurance, you said, "In the past, Virginia has worked with Maryland to conduct on-site financial examinations." When GHMSI's 1991 annual statement indicated major reporting problems and troubling financial developments, especially in its relationship with subsidiaries, Virginia not only required filing of an amended annual statement, but dispatched examiners in April of last year to conduct an on-site target review of critical areas.

My question is: Is that really the first indication of difficulty that you had, or did you have prior signals or prior warning?

Mr. FOSTER. Certainly, we had prior signals. This has been a plan, Senator, that we have had regulatory concerns about. I came in office in February of 1987, and these regulatory concerns probably were presented to me within the first 2 or 3 months I became commissioner.

We work with insurers like GHMSI, working from their quarterly statements and their annual statements. We don't place examin-

ers, for example, full time in the offices of each and every insurer. We are relying, because these annual statements, frankly, are sworn to, as to the accuracy of these particular numbers.

Given my frustration, Senator, particularly with the chief financial officer of this company in the past, we have always closely monitored this particular plan. Obviously, our ability to take regulatory action is affected somewhat by the extent to which they are able to continue to maintain their 45-day requirement, which roughly equates today to $45 million.

That $45 million is saying that, when you look at all of their liabilities, what they have set aside for claim reserves, and all of their assets, they have above and beyond their policyholder obligations; by today's measure, $45 million.

So one of the things to look at is, in spite of what problems we may have with their filing appropriate financial information, we have had to constantly measure the extent to which they remain above 45 days.

There have been very few companies that we have actually issued a formal show-cause letter to in my administration. We issued one to GHMSI in 1989 because we did not believe what they were saying. They kept saying that there was a shield being provided by the Federal preemption, but even in spite of that, they were subject to the District's Insurance Holding Company Act. We did not believe it.

We said, "Come down here in a public setting and tell us." We fully recognized, frankly, the effect even that could have on contract total confidence and the extent to which it could further exacerbate what may be, in some respects, a precarious financial condition at that time.

So regulators were trying to balance, frankly, aggressively regulating, to use that term, but at the same time looking at what the requirements are, being mindful of the effect on contract holders, and, in the end, doing what you think is best.

So, certainly, the first time that we saw something of concern, I would never suggest it was this past spring.

Senator ROTH. I guess what bothers me is that it was not until the problems were reported in its annual statement that, at least according to your written testimony, examiners were sent to conduct an on-site target review of critical areas. Obviously, after that, you took some pretty strenuous action.

Mr. FOSTER. Well, Senator, we were looking when we saw that annual statement, one, the condition of the annual statement—it was abysmal—but, two, what appeared to us to be a potential that they were not meeting the 45-day requirement. That is why we took the steps at that time.

Prior to that, they were above the 45-day requirement, and I don't know, frankly, what argument I would make, unless I thought that there was clearly otherwise precarious financial condition when this plan maintained an amount in excess of 45 days.

Virginia, frankly, has been chastised by some for having too high a requirement, and people look at us as being sort of out there on the front line creating problems, if you will, for this plan, because if you don't meet our 45-day requirement, then it may spell trouble

for other jurisdictions. I have heard this in the National Blue Cross/Blue Shield Association.

My response to that is I have an obligation to enforce Virginia's requirements. Certainly, I have been and I am still mindful of the effect of any action we would take to, if you will, pull the plug on GHMSI.

If word got out tomorrow that Virginia told GHMSI—and this is hypothetical—that they could not write new business in Virginia, GHMSI would have to notify every agent and broker, if they call them that, of that action. How long before contract holders would know that this plan was in trouble? An hour? Two hours?

So we have to move, frankly, cautiously with proper regard for due process. Our statute provides for the extent to which we have got to put them on notice. They have a chance to be heard informally. Regulators, certainly, can be criticized after the fact for not taking in some people's eyes, perhaps, a different action or a more aggressive action, but, in the end, we have to look at to what extent this particular plan or any insurer meets the defined statutory and regulatory requirements of the plan.

That is not saying we can't make arguments otherwise, because I have with other insurers, that a particular plan's continued operation may, in fact, be hazardous.

Senator ROTH. Our time is running out. I appreciate the dilemma. At the same time, I am bothered as to what should be done when you write as you did in your statement, "This short history does not fully convey, however, the perennial resistance of GHMSI to make full and adequate disclosure in its holding company filings." It seems to me that there must be some way of dealing with this, and that is something we are going to have to struggle with.

Mr. FOSTER. Certainly, one way, Senator, is to take the license. One thing that has served to frustrate our efforts has been the failure of the National Blue Cross/Blue Shield Association to tell me what happens to northern Virginians in the event this plan, which enjoys their name and trademark, fails to meet our requirement. I don't think that was an unfair or tough question to ask back in August.

What you have to ask them is why would they not answer that question. I have an obligation to at least know the impact. If I say tomorrow that people in northern Virginia cannot purchase a Blue Cross/Blue Shield contract, there are lots of businesses and lots of individuals that will, on that date, not have access to the insurer of last resort in Virginia, because the folks in Chicago holds those rights and could prohibit any of the Blue Cross/Blue Shield Plan—Virginia, Maryland, or any other plan—to step in. That is of grave concern to me, and, frankly, I think they have an obligation to answer that question.

When you don't have answers to questions like that, you have to move very carefully and deliberately with proper regard for due process before you take steps that could leave Virginians in northern Virginia unable to purchase Blue Cross/Blue Shield contracts on the next day.

Chairman NUNN. Commissioner Foster, Superintendent Willis, we appreciate very much you being here. We may have other ques-

tions for the record.[1] We appreciate your cooperation, and we will continue to work with you.

Commissioner Foster, also, if you would, express our appreciation to the National association.

Mr. FOSTER. Yes, sir, I will.

Chairman NUNN. We look forward to continuing to work with them.

The hearing tomorrow morning will be at 9:30, rather than at 9 o'clock, as previously announced. We will have scheduled to appear: Mr. Gamble, who is the retired President and CEO; former Chairman Charles Duvall, Board of Trustees; Benjamin Giuliani, President and Chief Executive Officer; and Peter O'Malley, Chairman of the Board of Trustees.

Tomorrow morning at 9:30. Thank you.

[Whereupon, at 2:04 p.m., the Subcommittee recessed, to reconvene 9:30 a.m., Wednesday, January 27, 1993.]

OVERSIGHT OF THE INSURANCE INDUSTRY: BLUE CROSS AND BLUE SHIELD—NATIONAL CAPITAL AREA

WEDNESDAY, JANUARY 27, 1993

U.S. SENATE,
PERMANENT SUBCOMMITTEE ON INVESTIGATIONS,
COMMITTEE ON GOVERNMENTAL AFFAIRS,
Washington, D.C.

The Subcommittee met, pursuant to notice, at 9:36 a.m., in Room SD-342, Dirksen Senate Office Building, Hon. Sam Nunn, Chairman of the Subcommittee, presiding.

Present: Senators Nunn, Pryor, and Cochran.

Staff Present: Eleanore J. Hill, Chief Counsel; John F. Sopko, Deputy Chief Counsel; David B. Buckley, Chief Investigator; Mary D. Robertson, Chief Clerk; Scott E. Newton, Investigator; Grace McPhearson, Investigator; Alan Edelman, Counsel; Eleni P. Kalisch, Counsel; Harold B. Lippman, Investigator; R. Mark Webster, Investigator; Cynthia Comstock, Executive Assistant to Chief Counsel; Declan Cashman, Staff Assistant; Daniel F. Rinzel, Minority Chief Counsel; Mary E. Michels, Minority Counsel; Carla J. Martin, Minority Assistant Chief Clerk; Andrea Kamargo, GAO Detail; Larry Sullivan, GAO Detail; Dennis Clarke, GAO Detail; John Forbes, U.S. Customs Service Detail; and Gene Richardson, U.S. Agency for International Development Inspector General Detail.

OPENING STATEMENT OF SENATOR NUNN

Chairman NUNN. The Subcommittee will come to order.

Yesterday the Subcommittee heard testimony from our staff based on their investigation into the operations of Group Hospitalization and Medical Services, Inc. Through its wholly owned subsidiary, Blue Cross and Blue Shield of the National Capital Area, GHMSI provides health care coverage to 1.1 million subscribers in the greater metropolitan Washington area.

The staff's exhaustive 6-month review detailed how this plan has strayed from its intended purpose and congressional charter of providing low-cost health care coverage to the citizens of this region.

Yesterday the staff described a massive diversification program that has unwittingly cost the subscribers of this plan over $100 million. Yesterday, also, the testimony revealed what can only be termed a life-style of extravagance on behalf of many of the senior officers of the plan, ultimately costing subscribers millions of dollars in premiums.

We also heard from two of the regulators who have been faced with the unenviable task of attempting to sort out the international business transactions of this plan.

D.C. Insurance Superintendent Robert Willis and Virginia Insurance Commissioner Steven Foster detailed to us in yesterday's hearings the problems they face as well as some of the solutions they are proposing for regulating such an entity.

This morning we intend to hear directly from the plan's management and board concerning how the D.C. plan ended up in such a financial and management mess. Appearing this morning will be Mr. Joseph Gamble, who was the president and chief executive officer of the plan until his recent retirement. We will also hear from the former chairman of the board, Dr. Charles Duvall, who also recently retired.

In addition, Mr. Gamble's successor as president and chief executive officer, Mr. Benjamin Giuliani, will testify about his 30-year experience with the plan.

We will also be interested in hearing from the new chairman of the board, Mr. Peter J. O'Malley, who we expect to discuss the changes that he has instituted since taking over last October as well as his plans for the future.

So we will begin this morning by swearing in all the witnesses who will appear before the Subcommittee. We swear in all witnesses, so will each of you please stand and hold up your right hand and take the oath.

Do you swear the testimony you give before this Subcommittee will be the truth, the whole truth, and nothing but the truth, so help you God?

Mr. GAMBLE. I do.

Dr. DUVALL. I do.

Mr. GIULIANI. I do.

TESTIMONY OF JOSEPH GAMBLE, FORMER PRESIDENT AND CHIEF EXECUTIVE OFFICER, GROUP HOSPITALIZATION AND MEDICAL SERVICES, INC.

Chairman NUNN. Mr. Gamble, I believe you are represented here today. If you would like to introduce your counsel or have counsel introduce himself?

Mr. HOLMES. Good morning, Mr. Chairman. My name is Sven Holmes of the law firm of Williams & Connolly. With me is Attorney Eric Lieberman appearing on behalf of Mr. Joseph Gamble.

Mr. Chairman, it should come as no surprise that, under the circumstances, responsible counsel——

Chairman NUNN. Mr. Holmes, would you pull that mike up? You have to talk right into it.

Mr. HOLMES. It should come as no surprise that, under the circumstances, responsible counsel will advise Mr. Gamble to assert his constitutional right not to testify here today. That is what we have done, and that is what we will continue to do. Mr. Gamble will take counsel's advice and will refuse to answer any question under the circumstances of these proceedings.

Thank you.

Chairman NUNN. Thank you, Mr. Holmes.

Mr. Gamble, I am going to ask you a few questions. Do you live here in the Washington, D.C., area?

Mr. GAMBLE. On the advice of counsel, I respectfully decline to answer based on my constitutional rights.

Chairman NUNN. Is your name Joseph Gamble?

Mr. GAMBLE. Yes, it is.

Chairman NUNN. Will you give us your address?

Mr. GAMBLE. On the advice of counsel, I respectfully decline to answer based on my constitutional rights.

Chairman NUNN. Which constitutional right, Mr. Gamble?

Mr. HOLMES. Mr. Chairman, I must object to that.

Chairman NUNN. I think you have to be more definitive. If counsel could specify what the constitutional right is—the Constitution is a pretty broad document.

Mr. HOLMES. Mr. Chairman, the witness has a right under the Fifth Amendment of the Constitution not to testify. We have made that right clear by letter and by statement here today.

Chairman NUNN. Well, that is what I am asking. I am asking which right are you asserting. Are you asserting the Fifth Amendment right——

Mr. HOLMES. The Fifth Amendment, yes, Mr. Chairman.

Chairman NUNN [continuing]. Against self-incrimination?

Mr. HOLMES. Yes, Mr. Chairman.

Chairman NUNN. Is that correct, Mr. Gamble?

Mr. GAMBLE. Yes.

Chairman NUNN. Mr. Gamble, is it true that at a time when premium charges to D.C. policyholders were being increased and covered medical procedures were being reduced and losses were mounting, that you used GHMSI funds to pay for first-class Supersonic airfare, stayed in luxury accommodations, and entertained yourself, your wife, and other employees at the expense of the policyholders?

Mr. GAMBLE. On the advice of counsel, I respectfully decline to answer based on my constitutional rights.

Chairman NUNN. Mr. Gamble, did you ever mislead the board of trustees or the board of directors on the loss of the Medicare contract with the Federal Government, which took place in 1987? Did you tell the board what really happened there?

Mr. GAMBLE. On the advice of counsel, I respectfully decline to answer based on my constitutional rights.

Chairman NUNN. Mr. Gamble, is it your intention to invoke your Fifth Amendment privilege against self-incrimination and refuse to answer any questions which the Subcommittee may ask you regarding your activities with GHMSI and its subsidiaries?

Mr. GAMBLE. Yes.

Chairman NUNN. Mr. Gamble, you have availed yourself of the privileges afforded you by the Constitution of the United States. We respect these rights, although we would have liked to have had you testify today. We believe that your testimony could have assisted us in determining how best to combat fraud and abuse in the insurance industry, and particularly assisted us in determining how we can better protect the policyholders.

We understand your rights, however, and we respect them. We do hope at some point you will be willing to testify fully and truth-

fully before our Subcommittee. Because you have invoked these rights and because the other witnesses, I understand, will be testifying, at this point I will excuse you and your counsel.

Mr. HOLMES. Thank you, Mr. Chairman.

Chairman NUNN. Senator Pryor, we welcome you. We just started. If you want to make any kind of statement——

OPENING STATEMENT OF SENATOR PRYOR

Senator PRYOR. Mr. Chairman, thank you. I think in view of the number of witnesses that you have and the hearing that you are probably going to have, if I might, I will just put my statement in the record, Mr. Chairman.

Chairman NUNN. Good. Without objection, it will be part of the record.

PREPARED STATEMENT OF SENATOR PRYOR

Mr. Chairman, I would like to commend you for conducting this thorough investigation. Your staff has done a fine job in reviewing a very complex issue.

Health care reform is the phrase everyone hears today and reform is much needed. We must ensure that everyone can participate in a health insurance program. However, a major part of the reform movement must be ferreting out fraud, waste, and abuse. Roughly 10 percent of total health care spending, or $80 billion annually, is wasted through fraud or abuse of the system. We must not allow the insurance companies to forget that their prime mission should be the protection of the beneficiaries.

In 1988, we passed legislation to protect participants in the Federal Employees Health Benefits Program (FEHBP) from unfit health care providers, providers who have had their license suspended, and providers who have committed fraud or other types of financial misconduct. Unfortunately, the Office of Personnel Management (OPM) has not yet even begun to implement the law.

As a first step, OPM plans to begin debarring providers that have been debarred by other Federal agencies. However, this is not much protection. Medicare, the largest Federal health benefits program, has been classified by the General Accounting Office as a high risk program, partly because of its inability to police fraud in the system. I do not pin much hope, therefore, on simply relying on the debarment procedures of other Federal agencies. I am continuing to work with OPM to urge them to speed up its implementation of the fraud and abuse prevention legislation.

I look forward to working with you, Mr. Chairman, on issues involving health care fraud and again commend you for your efforts.

Chairman NUNN. As I have already mentioned, we have Dr. Duvall and Mr. Giuliani with us this morning. Each of you, I believe, is represented here today, and if you would like to introduce your counsel or they can introduce themselves, that would be fine as we begin. Then, Dr. Duvall, we will call on you for any opening remarks you would like to make.

TESTIMONY OF CHARLES P. DUVALL,[1] M.D., FORMER CHAIRMAN OF THE BOARD OF TRUSTEES, GROUP HOSPITALIZATION AND MEDICAL SERVICES, INC.

Dr. DUVALL. I would like to introduce my counsel, David Webster, from Caplin and Drysdale.

Senator it is good to be here and to have a chance to review these important issues that affect the citizens of this community with respect to the business of the Blue Cross and Blue Shield Plan of the National Capital Area.

---

[1] The prepared statement of Dr. Duvall appears on page 236.

Believe me, sir, the directors and management of this plan share your abiding interest in what is best for the customers and subscribers of this greater metropolitan area. We do care, and we care very much.

This is a public entity, a not-for-profit corporation, and in that sense does stand accountable for its actions. I have no problem with your review of them. When problems develop, the most important job is to analyze their cause and to provide creative solutions, as you are trying to do. We need more the helping hand than the accusing finger.

I am before you today representing not only myself, but the 40-plus men and women who have served proudly on this board and with great distinction over many years. At the time when the Blue Cross and Blue Shield organizations merged, the combined board was totally voluntary, 36 in number, 15 of whom were providers, by which we mean physicians and the hospital administrators. The rest, 21, were citizens of this community. Changes over the years have now reduced the size of the board to 12, with a single physician and single member of the hospital community.

Throughout the years, men and women, attorneys and physicians, those active in the political, social, and business life of this community, teachers, previous school board superintendents and university chancellors have served. We have had the benefit of service of Government workers with financial experience, of union leaders, bank officers, and insurance executives. These men and women were not only subscribers, but came on the board for the sole purpose of representing the subscribers of this community, and those interests were first and foremost on their list of concerns.

While the board minutes and staff report don't always reflect these concerns, I can assure you, sir, that they were present at all times.

One staffer suggested that these individuals were well-intended public servants, not fully appreciating the responsibilities that lay before them. I will agree to "well-intended." Yes, that is true. But nothing could be farther from the truth, in my opinion, with regard to responsibilities.

In the front of our minds was the charge of the director as a steward of the plan, and the sense of Trustees as servants was part of our board credo. And as a matter of fact, the Long Range Planning Committee at one point distributed that pamphlet articulating that idea.

Others have argued that the board did not exercise diligent oversight or that there was a shortfall in vigilance. And the Post picked up on the staff report that, indeed, it was negligent.

Simple hindsight could lead one to jump to that conclusion because problems, now recognized and admitted to, did develop. If vigilance, though, means being watchful and attentive and alert to changing circumstances, then, Senator, this board was vigilant And if diligence consists of a persistent and earnest effort to accomplish a given and set task, then we were diligent. Attendance at meetings was uniformly high, often perfect, and the homework was done. Whenever possible, the sincerity and industry of trustees even caused them to be patched through to the meeting when on

holiday or vacation in a remote location, once even including a 5-hour phone call this past fall.

One of our trustees, Mr. Chairman, came down with acute leukemia and soon thereafter suffered a relapse of his disease. Still, over a 2-year period of service, he missed only one paired set of board meetings when in the hospital. Further, he attended 8 committee meetings to which he was not even formally assigned and with no expectation of recompense—out of his own industry.

We grappled with the data presented and in the most responsible way and using our best business judgment dealt with that data while resisting the temptation to assume the roles of day-to-day management and administration, roles we were not required to assume and roles which we did not pretend to assume. We did focus on policy matters with regard to management performance. But the way things were set up, we had a single card to play; that was the management performance of the chief executive officer.

Mallory Walker, one of our board members, with some difficulty, in January of this part year assembled a spread sheet showing serious cumulative losses in the subsidiaries. In February, the Audit Committee met and made recommendations, based in part on these findings, which demonstrated the depth of our problems. When confronted with this picture, the Executive Committee and the Board moved aggressively and quickly to forge deliberate change.

A comprehensive, full-depth, outside, independent opinion was sought from the McKinsey Company, and a study was commissioned by the Board with the expectation of recommendations for substantial revisions of corporate operations. The designation of Ben Giuliani as the CEO to effect such change was coupled with the board approval of that report.

The professional relationship, Mr. Chairman, with McKinsey was with the board itself. The board was the client in this relationship, and we delegated the work to the Long Range Planning Committee.

Just after the 1st of July, requests for preliminary reports were made for matters felt to be urgent just after the 1st of July, and this led to an Executive Committee meeting in late July, at which time Mr. Giuliani prematurely assumed the leadership role of this enterprise on July 27, 1992.

Further, the board has looked to its own role in the new GHMSI, has further reduced its number and revised its bylaws and committee structure, as I think Mr. O'Malley may explain later.

I personally and all other board members have tried our very best, given the information available. Once aware of any possible incompleteness of such information, we remedied the problem and, as a matter of fact, have been addressing the matters of this Subcommittee for almost a year now. I will attempt to be as responsive as possible to your questions, Mr. Chairman. I would be hopeful if that during the questioning or at the end of it I could have an opportunity to respond to the salient three areas of the staff report affecting the board which have to do with the travel and spending, the compensation of the CEO, and I guess simply "why we didn't fire Gamble earlier."

Chairman NUNN. You say you would like to do that at the end of your——

Dr. DUVALL. I would like to do that at some point, if I could, Mr. Chairman, either through your questioning or at the end. Those are areas the Committee report has touched on. My expectation is your questions will cover that.

Chairman NUNN. Certainly you will be given every opportunity.

Dr. DUVALL. Thank you, sir. Thank you. Those conclude my remarks, Mr. Chairman.

Chairman NUNN. Thank you, Doctor.

Mr. Giuliani.

TESTIMONY OF BENJAMIN W. GIULIANI,[1] PRESIDENT AND CHIEF EXECUTIVE OFFICER, GROUP HOSPITALIZATION AND MEDICAL SERVICES, INC.

Mr. GIULIANI. Good morning, sir.

Chairman NUNN. Talk right into that mike. You have to talk right into it for it to pick it up.

Mr. GIULIANI. All right. Thank you.

As counsel, I have to my right Mr. Ty Cobb and Mr. Tom O'Neil to his right from the firm of Hogan & Hartson.

Mr. Chairman, members of the Subcommittee, my name is Ben Giuliani, and since July 27, 1992—6 months to the day—I have had the authority of the chief executive officer of Group Hospitalization and Medical Services, Inc. Prior to that time, I was the president of GHMSI's principal division, Blue Cross and Blue Shield of the National Capital Area, for nearly 4 years.

I want to thank you, Mr. Chairman, for this opportunity to appear today to respond to questions that have been raised about our business and the changes that have occurred in the past several months.

GHMSI has prepared a much longer statement, which sets forth in detail our responses to a variety of specific concerns raised during yesterday's hearings and in the media during the past several months. I will not read from that document, but I respectfully request that it be incorporated as part of the record in these hearings.

Chairman NUNN. It will be incorporated, without objection.

Mr. GIULIANI. Thank you.

In the mid- to late-1980's, the traditional role of health insurers began evolving rapidly. The staggering increases in medical costs required, in order to best service subscriber needs, that GHMSI develop new and better solutions to the increasingly complicated problems encountered in connection with our data processing systems. To that end, GHMSI invested heavily in developing new claims processing technology.

The FLEXX system which resulted from that effort has become an extraordinary success. Because of the flexibility and efficiency gained through the implementation of the FLEXX system, Blue Cross and Blue Shield of the National Capital Area, BCBSNCA, is able to pay 90 percent of its claims within 14 days and resolves over 90 percent of all telephone inquiries within 2 business days.

---

[1] The prepared statement of Mr. Giuliani appears on page 237.

Likewise, BCBSNCA has reduced administrative costs from 13.4 percent in 1986 to 8.2 percent by 1991.

That, however, was not the only customer-specific response required by the changing competitive environment. In addition to matching products offered by competitors, including, for example, life insurance, the pressure was intense for BCBSNCA to become increasingly engaged in managing the cost and quality of health care.

In addition to meeting these competitive demands within the core business, GHMSI also sought through a diversification strategy to reduce the competitive impact of down cycles customary within the industry. The well-intended purpose of diversification was to increase revenues and profits with which to support the core business during cyclical downturns as well as to expand GHMSI's markets beyond the tightly constricted, highly competitive geographic area in which it operates.

While much of the diversification effort was responsive to customer needs, including, for example, CapitalCare, our successful HMO, or was necessary to meet competition, such as providing life insurance and certain other products, unfortunately many of the subsidiary endeavors initiated by GHMSI, particularly in the international area, have proven unsuccessful.

In early 1992, as the year-end 1991 financial results were being compiled, the realization that GHMSI's overall subsidiary operations would be responsible for yet another sizable unanticipated loss, some within the organization, including myself, voiced concerns about the direction of the company.

Chairman NUNN. Mr. Giuliani, could I ask you one brief question there? Did you voice that concern to the board?

Mr. GIULIANI. I voiced that concern to the chairman of the board in order to get to the board. I voiced the concern to the then-Chairman Dr. Duvall.

Chairman NUNN. When was that? When did you first——

Mr. GIULIANI. That was in February of 1992, once we saw what the financial results for 1991 were actually going to be with respect to subsidiaries.

Chairman NUNN. Was that the first time you had notified the board directly of your concern?

Mr. GIULIANI. Yes, it was. The nature of that concern, yes.

Chairman NUNN. Thank you.

Dr. DUVALL. The board, having been previously and repeatedly assured by former management that the subsidiaries were turning the corner and expected to be profitable, understandably ran out of patience and initiated a critical self-examination of the company designed to review and address operations across the board.

McKinsey & Company, a very capable and reputable consulting firm, was brought in and assigned the task of this massive operational review. McKinsey was also asked to assist in advising the board in connection with the elimination and/or sale of underperforming or unnecessary subsidiary operations—a task to which the board has become absolutely committed and one to which I have dedicated my efforts since assuming my current responsibilities on July 27, 1992.

It is important that you and the public understand, Mr. Chairman, that before agreeing to become CEO and as early as February 1992, I offered to leave GHMSI if my 30 years within the enterprise was seen as an obstacle either to the important changes required or to the pace at which they could be achieved. Please do not be under the misimpression that I view myself as blameless for the situation I inherited upon becoming CEO. Likewise, please understand how grateful I have been for the opportunity to confront and seek solutions to the difficulties faced by the organization to which I have dedicated my professional life.

GHMSI's internal review, coupled with the heightened scrutiny attendant to the efforts of this Subcommittee, have produced radical changes within our organization. Pursuant to our new strategic plan emphasizing a return to focusing on meeting the needs of the metropolitan D.C. area subscribers through our core business, as CEO I have authorized the sale or elimination of 24 of the 45 subsidiaries which existed on the day I took office. I have targeted up to 10 others for sale or elimination this year.

Management and financial controls on the subsidiaries were implemented aggressively by me. The rosy financial projections routinely we see from subsidiary executives in the past were no longer tolerated. While many foreign subsidiaries had no place in a restructured GHMSI, decisions on other subsidiaries required careful financial analysis. Accurate financial reporting from those subsidiaries was critical to my mission of determining which were either underperforming or unnecessary to support the core business.

In the first minutes of my tenure, I eliminated problematic travel and expense policies. I, in essence, made them to be consistent with that which I had within the Blue Cross/Blue Shield operation. Other priorities included staff reductions starting at the top. Officer positions were reduced by nearly 25 percent. A hiring freeze was instituted within the organization. Reining in costs and expenses has been emphasized successfully.

Another important effort involved mending relations with certain of our regulators and with our national association by emphasizing within GHMSI the importance of being responsive to their informational needs. Enforcing this directive required difficult personnel and related actions.

Despite the time and resources required by regulatory issues which persist in Virginia, GHMSI has succeeded in sharply defining and dealing with the reality of our balance sheet by, 1, abandoning the broader diversification strategy which had resulted in troubling losses; 2, focusing on the core business, and, 3, emphasizing only those subsidiaries which are necessary to support the core business. That effort has enabled us to develop a comprehensive business plan for 1993 that GHMSI believes will result in adding $13.6 million to its reserve levels this year, 1993.

In addition, GHMSI is pursuing the option of an affiliation with Blue Cross and Blue Shield of Virginia. Such an affiliation holds great potential for this area. The combined entity would be a major force in the region and provide substantial subscriber and customer benefits in the highly competitive and challenging era of managed care.

Those discussions are at a sensitive yet constructive stage. In the affiliation discussions, GHMSI's priorities are the interests of its subscribers, employees, and providers. The multiple regulators whose support will be important to the affiliation are critical to the process.

It is the hope of GHMSI that with a cooperative, constructive, and responsible approach by the regulators, either through the affiliation or otherwise, GHMSI's restructuring efforts and its demonstrated commitment to those efforts will enable GHMSI to extent its 60 years of dedicated service to the community.

Thank you, Senator.

Chairman NUNN. Thank you, sir.

First, let me say that we do appreciate the cooperation we have had from the plan in terms of information. We have had a flow of information and you have cooperated with us in that respect, and we are grateful to you for that, and I would like to make that clear for the record before we proceed.

Mr. GIULIANI. Thank you, Senator.

Chairman NUNN. Mr. Giuliani, you mentioned on page 5, quoting your statement, "The rosy financial projections routinely received from subsidiary executives in the past were no longer tolerated." Let me ask the staff to put up a chart showing those subsidiaries.[1] We had that up yesterday.

Which of these subsidiaries in particular, Mr. Giuliani, was filing rosy financial projections?

Mr. GIULIANI. Towards the bottom half of the chart, those identified, for example, under International Health Benefits, Inc., those general categories, National Capital Administrative Services, National Capital Reinsurance, and there are two of those, Protocol, World Access, those are typically the ones in the past that we have received what I would deem to be rosy financial projections.

Chairman NUNN. Would those border on misleading reports, or would you term them fraudulent reports? How would you term them?

Mr. GIULIANI. I would term them as being overly optimistic, marketing driven type of reports of great revenues being received in the future and, therefore, resulting in financial results as they were projecting.

Chairman NUNN. Would those have been misleading to the board, if they had examined them?

Mr. GIULIANI. Insofar as the boards of those subsidiaries?

Chairman NUNN. The board of the overall parent.

Mr. GIULIANI. I don't think so, because, upon explanation, comments were made by the subsidiary CEO about why they thought these things were going to occur. They had their business plan about why this would happen, and it turned out to be extremely optimistic.

Chairman NUNN. Well, they turned out to be misleading, right?

Mr. GIULIANI. Yes, sir, in the sense they were overly optimistic regarding bottom line financial results.

---

[1] See page 237 for Mr. Giuliani's prepared statement.

Chairman NUNN. If you were a member of the board, if you were Dr. Duvall and you were chairman of the board, would you have been able to get a good assessment of what was really going on by reading those reports?

Mr. GIULIANI. If you read the reports themselves and heard the staff report on those, most likely, no, sir, but obviously they all end up being—for the most part, they end up being wrong.

Chairman NUNN. Now, tell me again the name, and let's go one at a time, which of those in particular are you talking about?

Mr. GIULIANI. There is the IHBI (Ireland) in particular would be one. National Capital Administrative Services would be one, but to a greater degree, National Capital Reinsurance, those two, one located in Ireland, one located in Barbados.

Chairman NUNN. You mentioned World Access and Protocol, also, right?

Mr. GIULIANI. Yes, that's correct.

Chairman NUNN. Is that Protocol, Inc. or Protocol Administrative Services.

Mr. GIULIANI. That is Protocol, Inc.

Chairman NUNN. Now, as I view that chart, Mr. Giuliani, you were an officer and on the board of most of those subsidiaries that were filing those reports, weren't you?

Mr. GIULIANI. Yes, sir, I was. However, I think you need to understand from my perspective, those were titular boards. Those were not boards where the overall ongoing operational issues of those subsidiaries were brought to. Those boards met, at most, three times a year.

The way this organization was structured, particularly from 1988 on, was we had the Blue Cross-Blue Shield Division and then seven other divisions made up of the diversification areas, all those subsidiaries were in those seven divisions. Those seven division heads all reported to Mr. Gamble, as I did. They did not report to me. Those boards functioned purely for legal reasons, for the most part. Very seldom were real business issues brought to those boards for review and approval, and if they were, the arrangements between the CEO of the subsidiary and Mr. Gamble, frankly, had already been discussed and the conclusions were reached and that was it. It was his area, that is, the subsidiaries were Mr. Gamble's area.

Chairman NUNN. He ran all of these, in effect?

Mr. GIULIANI. Absolutely. The ones under Blue Cross-Blue Shield, Mr. Chairman, to make sure you understand, that were under my responsibility, were Capital Care, POS towards the bottom of the page, and EMTRUST in the top third. Everything else was in Mr. Gamble's area. That is where he dedicated his efforts, because he thought that was the future of the company, not Blue Cross-Blue Shield.

Chairman NUNN. Did you agree with that assessment?

Mr. GIULIANI. No, sir. I realized Blue Cross-Blue Shield had its problems, but when I came in in 1988 and he said then you run Blue Cross-Blue Shield, I became the president and CEO of Blue Cross-Blue Shield, and it lost money for 3 years in one of those cycles, understand, business cycles in this industry.

We quickly turned that around, we reduced expenses. We reduced expenses to the point where, frankly, I made Blue Cross-Blue

Shield employees at that time, probably 2,500 of the maybe 3,000 employees in the company, take fringe benefit reductions, that when I went to Mr. Gamble and asked him for the other 500 to take, he refused to do so.

I took Blue Cross-Blue Shield, I turned it into a profitable organization. We have now made money—we believe we are going to end up making money this year—4 years in a row, despite the so-called 3-year cycle, because of changes we have implemented to attempt to deal with that. We have not eliminated it, but we think we are beginning to deal with that cycle and what creates it and how it can be impacted.

But more so, we became much more involved in becoming a customer focused organization. We also moved this company, Blue Cross-Blue Shield, in the area of managed care. That is the future of this industry, managed care. We brought in people to bring in expertise that we didn't have, to help us move in this area.

We also began to do for the first time customer surveys, have our customers tell us what they think of us. And the first time we received that information, we got a pretty impressive report card, but it is not good enough. Between 75 and 79 percent of the customers said that they were satisfied or very satisfied with our performance. We must do better than that, obviously.

Chairman NUNN. Well, what role did you play in the establishment of these subsidiary organizations that lost all this money?

Mr. GIULIANI. Early on, Mr. Chairman——

Chairman NUNN. You were on the board of a number of them. You are saying the board was nothing but a titular board. Do you mean by that, that the board really didn't have any authority or exercise any supervision?

Mr. GIULIANI. Absolutely none, sir, as far as I was concerned.

Chairman NUNN. Would you say the board didn't exercise due diligence in any of these subsidiaries?

Mr. GIULIANI. This arrangement with respect to wholly owned subsidiaries, which most of these were, is a common arrangement within organizations insofar as subsidiaries being established for legal reasons, but they are really operated——

Chairman NUNN. They are all operated out of the hip pocket of Mr. Gamble?

Mr. GIULIANI. They are operated by Mr. Gamble, yes, sir.

Chairman NUNN. In effect, then the boards didn't have any real function?

Mr. GIULIANI. Legal functions, yes. When there were legal issues that had to be accomplished, yes.

Chairman NUNN. But in terms of——

Mr. GIULIANI. At times, there were some business issues, plans presented, but as far as I knew they were done deals, Mr. Chairman.

Chairman NUNN. As far as exercising real control over the company, the board really didn't play a role?

Mr. GIULIANI. The boards of those subsidiaries?

Chairman NUNN. Yes.

Mr. GIULIANI. No, sir.

Chairman NUNN. And did you ever protest this to Mr. Gamble? Did you ever tell him that you were concerned about the way they were being operated?

Mr. GIULIANI. I went to Mr. Gamble on a number of occasions on various issues, starting back, my recollection, in 1986, publicly as well as privately, about our administrative costs increasingly excessively, and we need to begin to deal with this.

I went to Mr. Gamble on an issue dealing with Blue Cross of Jamaica. Why? Why are we doing this? How do you get your money out of it? I went to Mr. Gamble on a number of issues with respect to activities that I had learned that the company was beginning to undertake.

Probably the most common area of debate was the Concorde. Now, I want you to understand, Senator, I did fly, at Mr. Gamble's suggestion, on the Concorde one time in 1985, one-way from here to London to negotiate two hospital contracts at his suggestion. I found that I could not cost justify or defend the use of that travel. I know your staff report yesterday put me in the category with others, but it was one time when I traveled on that plane. The Concorde was probably the most frequent area of disagreement, of constant debate, why, how can you defend it. It is not the way business should be conducted, and it was——

Chairman NUNN. Did you ever report that to the board?

Mr. GIULIANI. I reported that, when I went to Dr. Duvall, I mentioned that. I thought he would be aware of that through a process of approving corporate account activity. When I subsequently reviewed the GHMSI corporate account activity, I can see why he didn't now about it. It was deemed to be first-class travel.

Chairman NUNN. Did you know that they were pulling out the excess charges between a Concorde first-class pass and tourist and putting that in that corporate account?

Mr. GIULIANI. That I knew they were doing, yes.

Chairman NUNN. You knew that?

Mr. GIULIANI. I knew that, absolutely, yes, sir. The concern was the company was paying for it, surely. It didn't matter how the accounting was done, it would end up being an expense of the company.

Chairman NUNN. Did you think it was correct and right to put that in that corporate account so that people would not be able to see the true cost of travel?

Mr. GIULIANI. That corporate account was probably set up in the late 1980's with—excuse me, late 1970's with probably pretty good intentions. My assessment of that account, that account has been abused and I do want to let you know, Mr. Chairman, that in mid-November I closed that account. I feel that account is not appropriate, because it was simply abused.

As I reviewed the information of transactions in there, I could not justify continuing that. I had asked for an outside review, to make sure my conclusions were correct, because the original intention was certain expenses could not be charged to Federal programs, FEP and Medicare, and the view was, well, if we don't charge them, we shouldn't charge it to non-Federal subscribers, and this account was set up to accomplish that.

I think they probably had good intentions day one. Just as I now see, it got very abused, particularly in the late 1980's, very abused.

Chairman NUNN. Would the board, in looking at those expenses, be able to tell the amount of money that was going into that corporate account that was really for the payment of air travel?

Mr. GIULIANI. They could only see the difference between what was paid for the air travel and the commercial—excuse me, and the coach fare. That difference is what was charged to this account.

Chairman NUNN. Did you ever go to the board and tell them that the Concorde use was excessive? Did you ever talk to the board about it? Did you ever talk to Dr. Duvall?

Mr. GIULIANI. I talked to Dr. Duvall about it. I mentioned the Concorde to him when I met with him in February of 1992, but, admittedly, I thought all along they knew it was there, because it was being reviewed every 6 months with respect to what was in the corporate account. But when I reviewed those files, once I assumed this responsibility, it was never identified as Concorde. In fact, I even asked our internal auditor recently, if you reviewed that file, could you have ascertained that the Concorde was being used, and his answer was no.

Chairman NUNN. Did you attend the board meetings, the large board meetings?

Mr. GIULIANI. Yes, sir, I routinely did.

Chairman NUNN. You went to all of those?

Mr. GIULIANI. Yes, sir.

Chairman NUNN. Give us a little description of what took place at the board meetings.

Mr. GIULIANI. There were the usual minutes of prior board meetings and committees to be approved, financial reports. Particularly in the Blue Cross-Blue Shield, understand, Senator, there were two boards from 1988 on. There was the GHMSI board and there was as BCBSNCA board. I was responsible, obviously, for the activities of what went on at the BCBSNCA board. At those meetings, there would be the usual business activities of minutes. At the Blue Cross-Blue Shield meetings, there was always a presentation on financial results. At the GHMSI meetings, there often was not, because the information simply was not available, developing new systems together, all the information associated with all those subsidiaries.

Then there were proposals regarding any of the changes required for legal or business reasons. Usually a CEO report was presented at those meetings.

Chairman NUNN. Did you think that the information that the board was being given—I assume Mr. Gamble was making the main presentations, or were you also making presentations?

Mr. GIULIANI. He made most of the presentations. I would make them on certain areas where if I had any expertise. But in the GHMSI, there were very seldom presentations, if I recall.

Chairman NUNN. As a general matter, do you think the board was being fully acquainted with the pertinent facts relating to the management of this company and the subsidiaries?

Mr. GIULIANI. In some of the internal reviews that we have undertaken in the last 6 months, there may be some areas where some questions could be raised about that. But I saw the allega-

tions raised yesterday in the report, which did surprise me, in the staff report. But to my knowledge, I have no evidence of Mr. Gamble intentionally misleading the board.

Chairman NUNN. How about you, Dr. Duvall, do you think the board was fully acquainted with the matters that you should have been, in order to give your degree of due diligence?

Dr. DUVALL. We thought at the time we would review reports and make decisions, that we had a full deck of cards. It has been characterized by several of your witnesses, Mr. Chairman, that too often the reports were rosy. In that respect, it was hard to keep track of who was on first at times, because of the optimism inherent in the report.

Chairman NUNN. Did you know about this corporate account where the Concorde charges and other charges that were above the normal ordinary flight charges were basically accounted for?

Dr. DUVALL. I knew very little as to the exact nature of the account. I signed off on a front-sheet table of contents roughly on a 6-month basis. Mr. Gamble would bring a stack of this kind, with several categories of expense, one of which was first-class air travel. He explained to me, when I assumed my responsibilities on the board, that this is sort of what the chairman does, this particular category, for example, is first-class air travel, and often I would ask or leaf through it, and that is what would appear.

There would be expense reports with first-class air travel on it. I said, "Is all of this okay?" and he said "Yes," and then I would sign off on it. I had no idea, Mr. Chairman, that there was any Concorde in there once. That did not come to my attention.

Chairman NUNN. Well, do you think you were misled then by Mr. Gamble?

Dr. DUVALL. Let me just say that during those years, Senator Nunn, we respected and trusted our CEO, and I think a board should do that. In that context, I felt comfortable in signing off on that. You can draw your own opinion as to whether you think that trust was violated.

Chairman NUNN. Well, I think you would have to draw that opinion, doctor, not me. You were the chairman of the board and you now see what was in that account. The question is whether you were misled, not whether I was misled.

Dr. DUVALL. I feel like the Trojans when they opened the horse and found some Greek citizens inside.

Chairman NUNN. So you were surprised?

Dr. DUVALL. Yes, sir, I was. When Mr. Giuliani explained this to me in our meeting in February, I was surprised.

Chairman NUNN. The Trojans were deceived. Were you deceived?

Dr. DUVALL. I had no idea that that was in there, and I still don't know exactly what is in the whole thing.

Chairman NUNN. Do the other members of the board have any more knowledge than you do?

Dr. DUVALL. I would seriously doubt that, unless matters of this nature came from Price Waterhouse, our accountants—our auditors, excuse me, to the audit committee. But I was never aware of that concern circulating through that loop.

Chairman NUNN. Mr. Giuliani, who was the CEO of the company when Mr. Gamble retired? You had taken over at that time, had you not?

Mr. GIULIANI. Yes, sir. Mr. Gamble retired on November 12, 1992, but the executive committee and the board, on July 27th—excuse me, as of July 27th, gave me the authority, they gave me a title of president-elect and chief operating officer, but they gave me the authority of chief executive officer. I just want to make sure that is clear.

Chairman NUNN. Would the staff put the going away gift up there, the collage?

Are you familiar with this gift that was given to Mr. Gamble, Mr. Giuliani?

Mr. GIULIANI. Yes, sir, I certainly am and I appreciate your asking me, because I would like to comment on it.

Chairman NUNN. Yes, sir.

Mr. GIULIANI. I was approached by Mr. Gamble's secretary 18 months or 2 years ago, I don't remember exactly, about Mr. Gamble's retirement gift, whenever he may decide to retire. I certainly knew that that would be 35 years or more of service, and there was a group of us that talked about—and we were basically interviewing this company that does these things—and it was agreed, and I agreed, that given his long tenure—again, this was in the period of time when things didn't seem to be so bad, Senator—that I agree that we would go ahead and pay for this.

When those installment payments, after the work was being done, came in, I believe there were two of them after I assumed the responsibility of the CEO, I looked at those and concluded there is no choice. This was an agreed upon effort that we had asked this company to do, a well respected organization to do. If we terminated now, the work had been done was useless, because you couldn't sell it. So I decided that we had made a commitment, there were installment payments due, and I decided we were obliged to pay for this collage.

Chairman NUNN. When did you make the commitment?

Mr. GIULIANI. The commitment was back like 2 years ago, 18 months, whenever the meeting was with the people with respect to this idea as a retirement gift.

Chairman NUNN. Did you authorize that?

Mr. GIULIANI. Yes, sir. Yes, sir, I did.

Chairman NUNN. So this was your responsibility?

Mr. GIULIANI. Yes, sir, this was my responsibility and I do regret that that has occurred. Senator, I am sensitive to this issue with respect to using company funds, because I felt we were obligated to pay this, because the commitment was made. There is a usual retirement function for executives when they retire. I have seen this in the past, and there was a retirement dinner given where Mr. Gamble was presented this. Normally, that dinner would have been paid for by the company. I know your staff report cited that yesterday. That was paid for by me personally, because I did not think this was an appropriate expenditure the company and the subscribers should bear.

Chairman NUNN. So that $2,000 was not paid for by the company, that was paid for by you?

Mr. GIULIANI. Two thousand eight hundred dollars and some. I do have a copy of my cancelled check or whatever.

Chairman NUNN. Did you ever think about taking up donations from the loyal staff to pay for the going away gift, rather than having the subscribers' money pay for it?

Mr. GIULIANI. No, no decision—I guess in the last 6 months I have made thousands of decisions, Senator, and none of them embarrass me more than this decision that I felt I had to make, as a commitment was made to these people.

Chairman NUNN. Dr. Duvall, did the board know about this gift?

Dr. DUVALL. No, sir.

Chairman NUNN. Do you think the board should have known?

Dr. DUVALL. I think it is almost a metaphor for the corporate culture of senior management staff under Mr. Gamble at that time. I think if the board had known about this and that and the other thing, any one of them might have triggered unusual interest in what was going on. In that sense, it would have been nice to know about it, but this was in the management layer and was not surfaced to the board.

Chairman NUNN. If you had known about what the staff revealed yesterday, if the board had been acquainted with what the staff revealed yesterday, what action would you have taken—if you had known about these kind of expenditures, not simply this, but the Concorde, the hotel rooms, the expenditures relating to entertainment and all of that? Did you know about that? You said that you wanted to make a statement on it, and maybe this would be a good time.

Dr. DUVALL. I think it would be appropriate to.

The staff report details considerable excesses. I guess to make a fair judgment about that, you would have to do a business related analysis of how typical those procedures were within the industry and return on the investment and all kinds of things like that. If the board had known about that pattern of behavior, it would have prompted further inquiry.

As the board was set up and as it functioned, this was, as I mentioned, within the administrative layer and protected by a shell from the board. No board member ever went on any of those trips. You will not see my name on any of those things. We were not invited or expected to go. It was totally a staff function.

Further, the board has to rely on the information it gets from sources and consultants, and no qualification or other detail was pointed out by Price Waterhouse or our auditors or the audit committee or anything of this sort, so the board attracted as much attention on this as a stealth bomber.

Chairman NUNN. Looking back on it, what would you have done if you had known about it?

Dr. DUVALL. I think we would have embarked into a study of this particular area of corporate culture and corporate expenditure. As Mr. Giuliani has done now, we would have ordered audits on the senior management team. He has already done that. He has called in the artillery on his own camp, and we would have done what we had to do.

Chairman NUNN. Would you have fired somebody? Do you think that what you have heard here in the last 2 days were grounds for firing Mr. Gamble?

Dr. DUVALL. I think if we had developed a—I think a study our board would have done would have gone beyond what your staff has done, indicating or trying to analyze the business purpose of various things. It may be that, of 21 Concorde flights, the only way to do the job was with a couple of them, but it may be that some of those or an occasional one was indicated. We would have done a thorough analysis of that. It would be hard to see what the result of that study was. We never did get to it. We relieved Mr. Gamble on other grounds.

Chairman NUNN. What were the grounds you relieved on him?

Dr. DUVALL. Would you like me to go into that process that began with Mr. Giuliani's phone call that he has——

Chairman NUNN. I think we would be interested in that, yes, sir.

Dr. DUVALL. I would like to respond to that, because I think it does highlight how the board did function and could function.

I guess one of the things I was asked to respond to is this question of why didn't we fire him earlier. That is essentially your question, is that correct?

Chairman NUNN. Yes, sir.

Dr. DUVALL. And on this basis, too. The reasons we relieved Mr. Gamble of his leadership had to do with the financial results of the operation and a needed change in strategic direction. And, as a matter of fact, the kind of information we are talking about supplied by the metaphor to my right wasn't known to us. We did this for business related reasons.

In 1990, we saw that early in the year projections seemed to deteriorate through the year, but by the end of the year, Blue Cross business was making money and we saw the same kind of pattern going on through calendar year 1991. One member of the board, Mallory Walker, took it upon himself to try to chip away at the financials coming from the organizational chart that you saw there, separating out oranges from apples and this kind of thing, and in that setting provided us with a flow sheet which showed not only the marked variance of projections through the course of the calendar year, but also, for the first time, clearly showed that the losses were starting to be cumulative, and these were in the subsidiaries, I would also add, Senator Nunn.

At about the same time or shortly after that, I did receive a phone call from Mr. Giuliani. His voice was serious, his message was specific and sincere, and for the first time he said, "Mr. Chairman, I have serious concerns about the direction this enterprise is taking and specifically about the financial health and solvency of some of our businesses." Specifically the reinsurance businesses he did cite, I remember that. I don't recall anything else he said.

He was in my office on his way home at 5:00 o'clock that evening.

Chairman NUNN. What time frame was this?

Dr. DUVALL. This I would say is mid-February.

Chairman NUNN. Of 1992?

Dr. DUVALL. Of 1992. He was in my office that evening at 5:00 o'clock, and we must have spent a couple of hours. We have since

then talked I would say hundreds of times, there certainly have been dozens and dozens of times on this issue.

He encouraged me to go to the audit committee meeting, something I wouldn't have normally gone to, since I am not technically sophisticated as are the members of the audit committee. But I did go and it was a watershed audit committee meeting. Your staff has reported on that. But basically, the same kind of numbers showing trends of concern were articulated, and Price Waterhouse clearly had concerns about the absence of a chief financial officer who was functioning effectively through the myriad subsidiary corporations.

The audit committee met further several times; I couldn't speak to how many times, but at least one or twice by phone and at least a couple of times by themselves, and at least one of those times was an *in camera* meeting with just the three audit committee members. That caused quite a bit of flurry of debate on the board, as to why they should do that.

From those deliberations came recommendations to retire Mr. Gamble and appoint Mr. Giuliani and to get about the business of finding out what is wrong with this corporation.

Chairman NUNN. When did you all make that decision? And was that an official board meeting?

Dr. DUVALL. That was the initial recommendation and presentation and characterization to me of the audit committee. Having been alerted to these many problems, my concern was very deep, I can assure you, Senator, but we didn't have any of the ice cold facts in hand.

Not all of the board was at speed with this, and so the executive committee met to take up the rather surprising and remarkable recommendations of the audit committee, and we crafted a plan, if I would say so, sir, that was more diplomatic and more likely to bring the board to attention and to a majority consensus on this matter, rather than throw down the gauntlet of divisive confrontation on a black and white issue. That Solomon-like, if you will, recommendation was to let's get a study to find out in-depth what our problems were, comprehensive, independent, out of the corporation, expert, reporting just to the board, as I characterized in my remarks. We knew we had to change. We knew we had to dump some cargo.

Chairman NUNN. When was this? I am trying to put this in terms of——

Dr. DUVALL. Mid-March, early April.

Chairman NUNN. Nineteen-ninety-two?

Dr. DUVALL. 1992, this was all in the spring. That recommendation to have a study, and once we knew where our ducks were lined up, once we knew what we were doing, it would be up to Mr. Giuliani to effect the new strategy of that study.

One of the first things Giuliani and I and the executive committee did was to recraft our mission or corporate strategy statement. That was in late July. But it was that way of going about the change process that brought the board along very quickly.

Chairman NUNN. But when did you finally decide to ask for Mr. Gamble's resignation?

Dr. DUVALL. Well, if you think about it—the staff report I think may represent this—the minutes are clear, the motion the execu-

tive committee crafted that the board accepted was that we will do a comprehensive study. As soon as that study is reported to the board and the board approves it, coupled and linked inextricably to that approval, is the installation of Ben Giuliani.

Mr. Gamble, as you can sort of detect from the background on when this collage project was due, had postponed his retirement date until well beyond the end of fiscal 1993, perhaps 6 months beyond that.

Chairman NUNN. Really, what I am getting at, did he retire voluntarily on schedule, or did you fire him?

Dr. DUVALL. Mr. Gamble had wanted to retire sometime in annual year 1994. We had expected that the McKinsey study would be ready in probably early October of 1992, and my expectation, as the leader of this particular activity, was we would have a special board meeting in early October and Mr. Giuliani would be installed formally then.

Events began to overtake us. Specifically, the long-range planning chairman, Mr. Frey, and myself, both independently, on our own hook, basically, asked for an early preliminary report from the McKinsey staff just 4 or 5 weeks into their assessment, asking them are there any matters of urgent concern that need immediate attention by this board? The answer of that preliminary analysis, Senator Nunn, was that, yes, there were many items of emergent nature, not the least of which, we were potentially in the process of getting in deeper and deeper as we spoke, and it was for that reason that the executive committee met again in late July, and at that time we accepted Mr. Gamble's own offered retirement announcement. I had other motions in my briefcase and I was not going to come out of there without a result of that kind. We took that result.

Chairman NUNN. What did you tell him in order to stimulate his retirement?

Dr. DUVALL. Mr. Gamble and I, on a personal level, had for over 6 months became increasingly distant and perfunctory, if you will. The McKinsey study, he was as part of that. He was interviewed and the interviews were very much like your staff interviews. They would get information, and he was part of that study, and I think he could see how the wind was blowing.

But the executive committee, I believe, met on a Wednesday afternoon of that week before the 27th, so it would be the 22nd or 23rd or something like that of this year. The day before that meeting, he got a letter from McKinsey stating that they had early and urgent concerns and they detailed—I don't have that letter at my fingertips, but they detailed an extensive array of concerns.

The morning of that meeting, Mr. Gamble received a letter from Mr. Giuliani in writing stipulating formally his concerns, and Mr. Giuliani can characterize that letter, if he wishes. It is your pleasure, sir. That is what we went into the meeting with. I had the cards, I think.

Chairman NUNN. So basically what did you tell Mr. Gamble? Did you tell him he had to leave, or did you tell him you would like for him to retire? What were the words that got him——

Dr. DUVALL. It was interesting, Mr. Chairman. I was chairman of that committee and I ran those meetings. Before I could call the

meeting to order in any kind of a formal way, Mr. Gamble stood and passed out among the committee members a statement or two, basically seizing control of the meeting, as it were, and explained that if someone is fired, that's one kind of business, but nobody can tell someone when to retire and I am hereby announcing my retirement.

Chairman NUNN. So he preempted what he thought was coming?

Dr. DUVALL. He preempted, but I think it was when he looked at his hand, he didn't have the cards.

Chairman NUNN. Could you characterize what Mr. McKinsey & Company told you about the condition of the organization?

Dr. DUVALL. With respect to the emergent meetings, meeting I asked them for——

Chairman NUNN. Well, you said that they said there were some things that were urgent.

Dr. DUVALL. Yes.

Chairman NUNN. What was the essence of their message?

Dr. DUVALL. They hadn't gone in depth in every single area of the enterprise and, as a matter of fact, if I could retrogress one moment, the day after our board received the letter of acceptance from McKinsey that they would be our consultant in this matter, the lead partner in the Washington office, Larry Kanerick, was in my office the next morning at 0700 and had a readout for me as to what I wanted him to do.

I highlighted the areas that Mr. Giuliani and I had characterized as the most problematic, and they did tend to prioritize some of their early investigation. So when we met again, at my request in July, looking for emergent problems, some of those areas were highlighted, and maybe some other areas that weren't as emergent, were.

Chairman NUNN. Why don't you just give us the drift of what they reported on? What were the areas they were concerned about and what were the problems?

Dr. DUVALL. The areas they were concerned about were the reinsurance business, which was active and continuing with contracts being written contemporaneously, they were——

Chairman NUNN. Those were such things as reinsuring companies that were doing business in Russia and Poland——

Dr. DUVALL. That sort of thing all over the world.

Chairman NUNN [continuing]. And reinsuring Lloyd's of London and that sort of thing?

Dr. DUVALL. That area of business. They were particularly concerned about Protocol and the B'nai B'rith contract, which were showing serious problems not only in the losses in administrative expenses on the one hand, but literally we had both hands going. On that other hand, it was in the reinsurance part of that business. Actually, they went across the entire enterprise.

Chairman NUNN. Did they get into the excessive travel and expenses, or was it all on the business side?

Dr. DUVALL. No, sir, it was all on the business side. I am not sure that had surfaced, and I don't think that was part of their charge to be in that.

Chairman NUNN. Mr. Giuliani, Dr. Duvall said that you wrote a letter. Basically, could you characterize that letter for us? What was your concern?

Mr. GIULIANI. Yes, sir. I went to Mr. Gamble sometime, maybe the day, the morning of the preceding day, I don't remember which, before this executive committee meeting, because I knew, from my discussions with Dr. Duvall, that things were getting to be critical, and I would have what I would call a showdown with Mr. Gamble with respect to my concerns about where this organization was heading.

I thought our reinsurance activities were an absolute disaster. I told him that I thought that the people leading many of these subsidiaries were not appropriate people, given the businesses that we are now in, that we have got problems and they need to be dealt with, that we need to have a change in direction of this company, we have got to get back to the core business, we have got to focus on what Blue Cross-Blue Shield has been all about and diversification.

While the strategy may, in many ways, have been pretty good, the implementation was terrible. He totally disagreed with those issues, and so I told him in my letter that I handed him, which he asked me not to give him, but I gave it to him anyway, and a copy of that letter went to the board, that said if you agree with these changes that we must make, would you please lead us; if you don't agree, then would you please retire, to let me take charge to lead the change. If you don't agree with the change and the board supports you, then the board had better select another CEO-designate, because I am the wrong person to lead this company. If it is status quo, they should not take me as their CEO.

That letter was given to Mr. Gamble that day and copies went to the board, all board members. I do want to note that Mr. Gamble, about the middle of November, shortly after he retired, sent me a letter in response to that, and I think a copy of that letter went to the board members, as well, indicating that, (1) my letter did not cause him to take the actions that he took, he had already decided to do that; and (2) that the enterprise is in decent condition, basically, with the potential sale of the building, sale of a subsidiary here or there, we can restore our reserves, not a problem.

Chairman NUNN. Do you agree with that?

Mr. GIULIANI. No, sir, absolutely not. That is why I made all the changes that started to take place since July. I would like to identify, if this is the appropriate time, Senator, the changes that we have tried to make in this organization, particularly in the area of diversification——

Chairman NUNN. We will get to that. Let me reserve that. Did Mr. Gamble get a bonus when he left? Did he have a golden parachute?

Dr. DUVALL. No, he retired, Senator. He would have a normal retirement, but he got no golden parachute, sir.

Chairman NUNN. What is his retirement?

Dr. DUVALL. Pardon?

Chairman NUNN. What is his retirement?

Dr. DUVALL. I do not know the specific——

Chairman NUNN. Do you know, Mr. Giuliani? Do you know his retirement, what is the retirement plan?

Dr. DUVALL. I know what your report says.

Mr. GIULIANI. The retirement plan basically has three components, if I may.

Chairman NUNN. I don't need the details. I am just trying to get the basic—what is he getting from the company now?

Mr. GIULIANI. Do you mean the amount of money?

Chairman NUNN. Yes.

Mr. GIULIANI. I don't know precisely. I would have to guess.

Chairman NUNN. He didn't get a bonus when he left? He didn't get any kind of bonus or lump sum?

Mr. GIULIANI. No, sir. Do you want to address that issue?

Dr. DUVALL. He did not get a discharge bonus, a golden parachute, and he did not get two bonuses that would for good performance have been provided for services in calendar year 1992, and he has threatened to sue us because of that, sir.

Chairman NUNN. He threatened to sue?

Dr. DUVALL. The board.

Chairman NUNN. Has he sued yet?

Dr. DUVALL. No, sir.

Chairman NUNN. He has not brought suit yet. Dr. Duvall, you say on page 3 of your statement,[1] quoting you, "Others have argued that the board did not exercise diligent oversight or that there was a shortfall in vigilance. Simple hindsight could lead one to jump to that conclusion, because problems now recognized did indeed develop. If vigilance means being watchful, attentive and alert to changing circumstances, then the board was vigilant. If diligence consists of a persistent and earnest effort to accomplish its given task, then this board was diligent."

Have you seen the statement[2] that has been submitted today and is now part of the record by Group Hospitalization and Medical Services, Inc., submitted January 25, 1993, Hogan & Hartson, counsel to GHMSI? Have you read this?

Dr. DUVALL. I have read through parts of it. I haven't read it page by page.

Chairman NUNN. Mr. Giuliani, have you read it?

Mr. GIULIANI. Yes, sir.

Chairman NUNN. Do you agree with it?

Mr. GIULIANI. Yes, sir.

Chairman NUNN. Let me just ask both of you, just thumbing through this, I haven't read all of it but I have tried to thumb through it this morning——

Dr. DUVALL. I have it before me, sir.

Chairman NUNN. On page 15 of this report, which is now part of the record, and I am quoting from the report, page 15, the bottom of the page: "A number of observations can be made concerning the subsidiaries, particularly those that did not directly compliment the core business. Too often, GHMSI embarked upon subsidiary ventures without a comprehensive understanding of the business, a clearly defined business strategy or objective management

[1] See page 236 for Dr. Duvall's prepared statement.
[2] See page 238 for the prepared statement of GHMSI.

criteria for measuring whether the subsidiary was meeting its purpose." Do you agree with that, Mr. Giuliani?

Mr. GIULIANI. Yes, sir, I do. That is a result of hindsight looking back about what happened. I believe those facts stated there are correct.

Chairman NUNN. Dr. Duvall, do you agree with that?

Dr. DUVALL. I agree with the hindsight analysis. I would just like to point out another page in the staff report, page 131, where I am quoted as saying, "In retrospect, he"—meaning me—"realizes the board did not have information to act responsibly." I actually did not actually say that, Senator.

That is a mischarcterization of what I said. I think this particular statement that you have articulated, it is hard to defend if you are using the hindsight. I mean that is the problem. We thought we had sufficient information and we tried very, very hard to use our best business judgment with each and every one of these ventures that had gone on.

Chairman NUNN. So, basically, you are saying that that statement is true, but only with hindsight?

Dr. DUVALL. That is correct.

Chairman NUNN. You basically felt that you had a clearly defined business strategy, is that right?

Dr. DUVALL. Yes, sir, that is correct.

Chairman NUNN. And you felt you had a comprehensive understanding of the business, the board did?

Dr. DUVALL. Yes, we did, we thought we did.

Chairman NUNN. You felt that there was objective management criteria for meeting whether the subsidiary was meeting its purpose?

Dr. DUVALL. I am not sure how to answer that.

Chairman NUNN. Well, let's move on. This same publication that has been submitted for the record said: "GHMSI never developed a system for rigorously evaluating subsidiary performance and eliminating those subsidiaries that showed consistent losses, with little prospect of profitability. This failing can be attributed to an absence of adequate management tools. Financial reporting for the subsidiaries was inadequate for an enterprise of GHMSI's size. Particularly, in 1990 and 1991 reports to the board indicating that the subsidiaries had turned the corner were later amended at year-end to show dramatic losses. The need to improve accountability for variances between actual and projected operating results became clear." Did you get those amended reports, doctor, as to the dramatic losses?

Dr. DUVALL. Yes, and this is the kind of thing that Mallory Walker was uncovering in January of this year, and when we got that information, Senator, we acted as I have described—in January of last year, pardon me.

Chairman NUNN. On page 17, this report says: "The deficiencies in management were further exacerbated by the absence of adequate management controls." Mr. Giuliani, do you agree with that?

Mr. GIULIANI. Yes, sir. However, this pertains to subsidiaries. I do want to make a comment regarding the preceding page about not having what I call an exit strategy. I went to Mr. Gamble—and I don't remember when—when the subsidiaries were obviously in

some cases ill-performing and said, Mr. Gamble, we have got to develop an exit strategy, we have got to develop a strategy that says when certain things occur, we have got to get out, we have got to stop the losses. He agreed with that. He announced that at some subsequent meeting. Probably two meetings later, he said no, there is no need to do that and it went back to the status quo. So I agree with respect to the subsidiaries, yes, sir.

Dr. DUVALL. For the board's part, Senator, I think we relied on the financial information to be the report card on how things were going, and we have talked about that.

Chairman NUNN. On page 18, this says: "Certain subsidiaries and groups, Protocol, an insurance division, being particularly notable, spent lavishly on dinners and corporate sponsorships. Often, the expenditures bore no relationship to the success of the subsidiary or even to the profitability of the customer account being entertained." Mr. Giuliani, did you know this was taking place?

Mr. GIULIANI. Did I know in advance this was going to be taking place? Yes, I overheard a conversation——

Chairman NUNN. Well, during this whole period of your employment.

Mr. GIULIANI. I'm sorry, are you talking about the trip to Hawaii? I am not sure I understand——

Chairman NUNN. I am just quoting this book that was filed by your company.

Mr. GIULIANI. In some cases, I was aware of it. In many cases, I have learned of it subsequent to my becoming CEO of the organization, based upon reviewing——

Chairman NUNN. Whose responsibility was this?

Mr. GIULIANI. The responsibility was Mr. Gamble's ultimately, if I understand your question.

Chairman NUNN. Yes, sir. Dr. Duvall, did you know that often the expenditures, lavish dinners and corporate sponsorship bore no relationship to the success of the subsidiary, or even to the profitability of the customer account being entertained? Did you ever know that?

Dr. DUVALL. I didn't know about them at all, Senator.

Chairman NUNN. It goes further on page 18 to say: "Mr. Gamble believed that all GHMSI executives should, as a matter of policy, travel first-class and some, including Mr. Gamble, became frequent fliers on the Concorde." Did you know about that, Dr. Duvall?

Dr. DUVALL. I knew about traveling first-class, but I didn't know anything about the Concorde, as I have explained. We didn't do—most of the travel——

Chairman NUNN. Did the board have any policy about expenditures at all? Did you give any guidance whatsoever to the executives of the company?

Dr. DUVALL. The board would have felt this is part of management's prerogative and corporate culture.

Chairman NUNN. So if management wanted to fly first-class all over as a matter of policy, that wasn't a matter for the board to be concerned with?

Dr. DUVALL. We didn't concern ourselves with it.

Chairman NUNN. On page 19 of this report, again, this is your report, it says: "Executives for fledgling businesses that are losing

substantial amounts of money should not fly first-class. Such spending practices send the wrong message to the overall enterprises and were halted immediately upon Mr. Giuliani's assumption of duties as chief operating officer. Indeed, the lack of control apparently fostered the belief within certain subsidiaries that there was a limitless supply of money." Dr. Duvall, does that disturb you, as a member of the board, to find that out?

Dr. DUVALL. As an explanation of what the corporate culture was like, that is disturbing.

Chairman NUNN. Do you think that again is strictly a management function, not a board function, setting a policy?

Dr. DUVALL. We thought it was a management——

Chairman NUNN. Do you think the board bears any responsibility, when basically your own report shows that there was a feeling in the subsidiaries that there was a limitless supply of money? Does the board bear any responsibility for this?

Dr. DUVALL. In think in hindsight, it does, Senator. You know, this is information the board didn't have with it. We were evaluating Mr. Gamble on material matters of business results and this kind of thing, and you heard what that led to. We were unaware of this sort of thing. We trusted Mr. Gamble. We relied on him. We had great confidence and faith in him up until early last year.

Chairman NUNN. Mr. Giuliani, is this Mr. Gamble's fault? Who is responsible? Who is responsible, or do you agree with page 19, where it said, "Indeed, the lack of controls apparently fostered the belief within certain subsidiaries that there was a limitless supply of money"? Do you agree with that?

Mr. GIULIANI. No, sir. There is never a limitless supply of money. The actions I took the first moment, after he announced to his people and then our report to me, was you don't fly first class any more. I don't agree with any of this. There was an attitude, yes.

Chairman NUNN. Yes, but do you agree with the statement in this that there was that attitude?

Mr. GIULIANI. There was an attitude among some, yes.

Chairman NUNN. That there was a limitless supply of money?

Mr. GIULIANI. That we have plenty of money, it's okay.

Chairman NUNN. Whose fault was that?

Mr. GIULIANI. I look at it to be Mr. Gamble's.

Chairman NUNN. Nobody else, just him all by himself?

Mr. GIULIANI. As well as some of the subsidiary CEO's obviously reflected in their actions, in my view, that the views Mr. Gamble was expressing.

Chairman NUNN. Have you got anybody in mind that you believe was responsible besides Mr. Gamble?

Mr. GIULIANI. Well, let's just say that two individuals that come to mind are no longer with the organization.

Chairman NUNN. Have you fired some of them?

Mr. GIULIANI. Yes, sir. I don't know if you want to use the term "fired," however you want to characterize it, Senator, they are no longer with the organization.

Chairman NUNN. Who are they?

Mr. GIULIANI. Mr. Kestel and Mr. Riley.

Chairman NUNN. What were their positions?

Mr. GIULIANI. Mr. Kestel ran the Insurance Division, which included the two overseas reinsurance companies. Mr. Riley ran Protocol.

Chairman NUNN. On pages 19 and 20, you say: "Another now obvious problem in the subsidiary operation was the extent of due diligence in advance of GHMSI commitments. The experiences with Blue Cross of Jamaica and Access America illustrate this problem. In the case of Blue Cross of Jamaica, GHMSI invested $5 million, without a detailed study of the economic and political climate in Jamaica or the true financial situation in the company."

It goes on to talk about other subsidiaries, and it goes into considerable detail. It seems to me that it is just covered with admissions that these subsidiary operations, doctor, were not looked into with any due diligence. Would you disagree with that characterization?

Dr. DUVALL. I think they represent the clairvoyance of hindsight. If you take the Jamaica Plan, for example, the initial characterizations to the board was that this would be an important centerpiece in international business in the Caribbean. There was a representation that the local Price Waterhouse people in Jamaica per se had looked at the matter, and while the plan needed some help in terms of its accounting practices and business practices, we could help them with that, but no particular problems were identified.

I have come to learn since then that that was an extremely, in all fairness to Price Waterhouse, of Jamaica, was as very perfunctory and quick read and was covered with caveats, as this was not a formal in-depth study.

Chairman NUNN. Did you all read that report at the board level?

Dr. DUVALL. We never saw that report to my best recollection.

Chairman NUNN. Did you ask anything of Mr. Gamble before you approved—I assume you approved, did your board approve the $5 or $6 million you put into Jamaica?

Dr. DUVALL. Interestingly, the characterization of that was, to the extent that it wasn't really the expenditure of funds, if you will, it was the purchase of real estate which would show us an asset, and so on a consolidated basis the corporate reserves would not be impacted at all. We have since come to learn that there is a definite difference of opinion about that asset and problems have transpired with that philosophy.

Chairman NUNN. Senator Cochran.

Senator COCHRAN. Thank you, Mr. Chairman.

I am curious, following up with what Mr. Giuliani said, about changes have been made to try to get the reserves in shape so that there would be no danger of inability to pay claims under these policies. What is your view right now about the adequacy of the reserves? Do you meet the State requirements at this time of Virginia, of the District of Columbia, of Maryland, the three that have jurisdiction over your operation as far as reserves are concerned?

Mr. GIULIANI. Thank you, Senator. After the discussion of yesterday, I appreciate your asking the question.

We have yet to finalize our December 31, 1992, numbers, but we have made, obviously, estimates or projections on which we have briefed the various commissioners. In fact, at one meeting we briefed all of them regarding what we thought it would be.

We clearly meet the D.C. and Maryland regulatory requirements. With respect to Virginia, we do meet those requirements once you include, understand, the $15 million surplus note from the National Association.

Now, there is a question with respect to accounting policies under statutory accounting relative to some of the actions that I have taken of getting ourselves—of divesting ourselves of some of these businesses. Under GAAP accounting, for example, we have got to record probably $20 million in 1992 for future loss contingencies, estimated losses that we expect to incur of some business that we are trying to get out of but have a continuous contract, expect to incur in 1993, 1994, and 1995. Under GAAP accounting requirements, those must be recorded in the year we made the decision to do that. That is 1992.

Under SAP, it is unclear. We are waiting for clarification from the regulators, particularly D.C., with respect to how that should be handled.

It is all part of the whole issue of relooking at this company in total and seeing what changes must we make as soon as we can. The 24 subsidiaries we have got now, with 10 more schedule, if it makes sense to continue to move out of them, we will do that, but also restructuring our cost. We have actually reduced our administrative cost on an annualized basis of around $30 million. We are at the point now, as we go in in our restructured organization—as I said in my report, in 1993 we expect to make $13.6 million in the entire GHMSI organization. That is due to the efforts made in the last 6 months to get us here.

Senator COCHRAN. Have there been any defaults on payment of claims to those who have claimed benefits under the policies?

Mr. GIULIANI. No, sir. We pay 90 percent of our claims, and we still do, within 14 days. We have got a portfolio of $90 million. That doesn't count the $15 million from the association. We are paying our claims on a timely basis, and we expect over the course of this year in total to have positive cash flow certainly with respect to the last 3 quarters. So we are fulfilling our obligations, Senator, and we see ourselves continuing to do so.

Senator COCHRAN. There has been some concern, I understand, raised about the impact of some of these abuses or exaggerated expenditures for various things by the officers and the impact that has on rates to policyholders. Is there any way that you can tell us the extent to which the costs of the policies, the charges that are made to those who are insured under these plans have been affected by the accumulation of abuse that may have been brought out at these hearings in terms of overspending, wasteful actions by officers or others?

Mr. GIULIANI. Senator, as a ball-park estimate, I believe the abuses, as it would be characterized, with respect to expenses and travel, et cetera, are certainly less than 1 percent of our revenue. I know this can be debated, and it will continue to be debated. But our actuary in Blue Cross/Blue Shield and I have had many discussions about it was never our attention to affect Blue Cross/Blue Shield rates with respect to what was happening in the subsidiaries.

Some people say that is impossible that will never happen, and it could be characterized any way anyone wants to. But it is my belief there was never any attention to affect the Blue Cross rates with respect to the subsidiary losses.

It does affect the reserves, understand, Senator. I am not trying to—I am just trying to—I am referring to the charges to subscribers.

Senator COCHRAN. With respect to the differences between the regulatory requirements of the District of Columbia, the State of Maryland, and the State of Virginia, you have talked about the differences that exist, and in the filings that have been made by your attorneys that is pointed out as well. Is this an argument for Federal regulation of this industry? Is there something that is clear that ought to be done by the Federal Government to standardize or have minimum standards for certain regulations, especially with respect to reserves?

Mr. GIULIANI. Senator, it is my belief that we are not there at this time. I think there is, let me call it, a window of opportunity for the National Association of Insurance Commissioners to look at this issue. I think there is a lot more sensitivity towards these concerns.

Yes, there are differences, and it may be in some cases that the differences may be appropriate by State or by company, I mean, if there is good business rationale with respect to protection of subscribers. So I would never assume that it would be appropriate to have an across-the-board, flat requirement.

First of all, in our business, in Blue Cross/Blue Shield, let's say our revenue, which this year is expected to be $1.7 billion, only 20 or 25 percent of that business is at risk. So you have got to really become quite sophisticated in analyzing a company's obligations with respect to what sort of reserve levels should they have to make sure the subscribers are protected.

I am sure we will find that Maryland and D.C. will be increasing their minimum reserve levels through legislation. I am sure that is the case. And they should be increased.

Senator COCHRAN. What are the prospects for merger with the Virginia Blue Cross Plan?

Mr. GIULIANI. Senator, that is a very sensitive issue. We are in negotiation discussions. Even this Friday there is another meeting. They are ongoing. They are very constructive. We are making progress.

Certainly, even after we come out, if we do—that is an "if"—with an arrangement, it requires the approval of the Maryland, the D.C., and Virginia regulators, as well as the boards, needless to say. And it is going to be—we have heard time after time from the D.C. insurance commissioner that this has to be in the best interest of all subscribers that this organization, GHMSI, serves—Maryland, D.C., and Virginia.

There has got to be a business case that supports the need why this is in their best interest long term.

Senator COCHRAN. Thank you.

Chairman NUNN. Thanks, Senator Cochran. We are delighted to have you back on the Subcommittee here.

Mr. Giuliani, did you get a letter dated November 8, 1991, from Mr. Preston Jordan of Blue Cross/Blue Shield Association? Do you recall that? Have you got a copy? [1]

Mr. GIULIANI. November of 1991?

Chairman NUNN. Nineteen-ninety-one.

[Pause.]

Mr. GIULIANI. Let me see if I can give a little background on this, Mr. Chairman.

Chairman NUNN. Do you recall the letter?

Mr. GIULIANI. Not specifically, but it doesn't surprise me that there is a letter.

Chairman NUNN. Well, I am not going to get into great detail on the letter, but it basically shows, I think you would agree, that there is some considerable alarm at the national level about the condition of the company in November of 1991. It also shows in the letter clearly that you had had a number of conversations with the writer of the letter, Mr. Preston Jordan.

Mr. GIULIANI. Yes, and that is what I was referring to, Senator. The two of us had a discussion when we attended a meeting. It was a side discussion regarding the problems that they were having, and he was approaching me in an effort to try to overcome these problems.

Mr. Gamble took the view that the information regarding subsidiaries on an ongoing basis is confidential information relative to GHMSI and should not be shared with the association; because on the board committees of the association that provide plan oversight, there are plan CEO's who are competitors in some of our areas of diversification; and, therefore, we should not provide them with the information. And I disagree with that.

Mr. Jordan came to me and said, "Ben, what can you do to help us? We need to get access to information."

We arranged for a briefing, which I think he might refer to in here. I don't think that really met their satisfaction. He then sent me the letter. I brought it to Joe and said, "Joe, I think we have got to give them the information they need. They need to understand not just Blue Cross/Blue Shield, but they need to understand the information for the total enterprise."

Chairman NUNN. No way in the world anybody could judge the condition of Blue Cross and Blue Shield without getting the view of the subsidiaries, right?

Mr. GIULIANI. Well, sir, I do want to make sure you understand, Senator, that at least annually, when we had to file our annual submission to continue to be licensed as a Blue Cross/Blue Shield plan—and the licensee is obviously GHMSI, the corporate name. With that filing, you had to submit all the information—excuse me, you have to submit information on the subsidiaries.

It was my sense what Mr. Jordan didn't have was the ongoing financial results during the course of the year, and they needed to understand where things were going. Once a year was not enough. So this led—I don't know if you want me to proceed about the out-

[1] Exhibit No. 18 is retained in the files of the Subcommittee.

come of this, because they were obviously coming to me and saying, "Can you help us?"

This led to, finally with Mr. Gamble's agreement, a breakfast meeting with Mr. Jordan and other people, including the chairman of the committee. In that meeting, there was a presentation that Mr. Gamble wanted us to make regarding a Price Waterhouse evaluation of GHMSI. They were obviously not very impressed, I would say in my terms, with the outcome, except to say on the part of Mr. Jordan, for example, "Oh, it is obvious you people do have some assets that are of greater value than may be on your books, but we still have a problem."

During the course of that breakfast and following discussions, it was finally agreed to, and I negotiated with Mr. Gamble that Mr. Jordan and one of his financial people from the association could come in and get a thorough briefing with respect to the subsidiaries. And that meeting, as I recall, took place in early January 1992.

Chairman NUNN. I would just ask the question this way: How long have you known that this organization that you work for and spent most of your life in, how long have you known that it was in real bad trouble financially?

Mr. GIULIANI. Senator, when I really got to be troubled was when I saw the 1991 results finally coming in in final form. If I can go back for a little bit of history, if this is all right?

Chairman NUNN. Right.

Mr. GIULIANI. In 1988, it was reported that the subsidiaries—I am just talking about subsidiary results. Blue Cross/Blue is a separate issue because in 1989 on we were making money.

In 1988, the subsidiaries lost $10 million—excuse me, $14 million, $14 or $15 million. Ten million was in CapitalCare, our HMO. That HMO came under my responsibility January 1 of 1989—excuse me, October 1 of 1988, to be precise.

In 1989, the combined subsidiary results went from a loss of $15 million down to $7 million. CapitalCare went from a $10 million loss to about a $1 million loss. HMS and some others began to make money. So the losses were halved, and it seemed like the overall strategy was in place. These were mostly start-up companies. I think the acquisitions—I was looking at your subsidiary chart. Three come to mind: AmCap, Blue Cross of Jamaica, and First Continental Life.

If I recall, most of the others were start-ups. In fact, all the others, maybe except Access America, which could be debated, whatever that would be.

Anyway, we expected a 3- to 5-year period of time before these things turned profitable, so that things seemed to be on target. When it came to 1990, the losses went to $13, $14 million. All of them were in one subsidiary, an acquisition where we took over. We were a 40 percent owner; we became a 100 percent owner in July—excuse me, in August of that year. Everybody else on a collective basis broke even, and the rationale was for Mr. Gamble about, well, this was the one-time deal, we have to do some consolidations, there are some expenses associated with this. So if you accept that premise, which he told the board, you can see an improvement, 1988, 1989, and 1990.

Now we come to 1991. Mr. Gamble reported, I believe, at the May board meeting—I am sorry, at the November board meeting, November of 1991, that the subsidiaries this year probably will lose $6 million, 5 of which is still in this Access America acquisition problem. Everybody else is close to breaking even, and by this time, HMS was making money, CapitalCare was making money, and quite a few of the subs were showing improvement. We still had the one problem.

However—those statements probably were true for 1990. I am not too sure for 1991. But in November of 1991, they were seeing losses of $6 million. In January of 1992, 2 months later, late January, early February, began to hear what Price Waterhouse was going to say about year-end results for subsidiaries. It wasn't 6; it was 21. And to me, that didn't even reflect my concerns yet about the future losses in reinsurance. One reinsurer was making money. Another was not. I had no confidence with respect to that business. So that is when I went to Mr. Gamble, first of all, to see if he agreed. He didn't agree. He didn't think this was a problem. Then I went to Dr. Duvall.

Chairman NUNN. Well, looking back on it, it seems to me an awful lot of blame has been laid on one person today, and maybe that blame is well placed, maybe it is not. But looking back on it, Mr. Giuliani, was Mr. Gamble just a bad manager? Was he negligent in his managing? Did he just make bad judgments? Did he run into bad luck? What was wrong?

Mr. GIULIANI. Mr. Gamble—I mean, I have worked with this gentleman for 30 years. To me he was a very effective manager for many, many years. Financial background the same as mine. It just seems to me that when the vision that he developed, which many of us initially, including me, thought was pretty dramatic, which he developed in the mid-eighties regarding diversification, I think that he became overwhelmed, or whatever it might be, with that concept, and it was a concept of growth. Growth, growth, growth was the view because he had a 20-year, as he called it, vision regarding where this company ought to be, needs to be. And we would debate about short-term results.

For a long period, he really wasn't concerned about short-term results. He was concerned about the long-term view of this organization, and you can't be bothered with those issues.

And the way I interpreted some of his recent correspondence in November, I am not too sure he has changed to this date.

Chairman NUNN. Well, what about the lax attitude on the part of the subsidiaries? Whether you have a long-term or short-term vision, it seems to me that any good manager would not want the subsidiary organizations to believe that there was just an abundant supply of money and that money could come from wherever. And that is reflected in your own report here. How is that compatible with good management?

Mr. GIULIANI. Senator, first of all, I would like—as you said earlier, we have been very cooperative with your staff, and I appreciate your saying that.

Chairman NUNN. You have.

Mr. GIULIANI. One of the first things that I did when I assumed this responsibility was to go to our people and say we must be to-

tally candid with the staff, we must reveal anything that they want and give them information. So I appreciate your saying that.

To me, this document continues that view. I think we have pretty well tried to lay out the good things and the bad things. So I hope you appreciate the candor we have tried to reflect in this document, because I think it does reflect what we are trying to do in this organization. So I appreciate that.

I think that one of the problems, among many, in hindsight—and I have told this to Mr. Gamble—was the lack of accountability that he had among the subsidiary CEO's. There was no—until forced upon him by the board in 1992, incentive plan, there was no specific accountability insofar as for results among subsidiaries, to my knowledge. So without that accountability—and accountability, if there was anything, it was growth, not bottom line.

Chairman NUNN. Could you put the chart up there about the number of days Mr. Gamble was traveling? Have you still got that chart? [1]

Mr. GIULIANI. I remember that chart. I surprised myself.

Chairman NUNN. One is enough.

Is this a normal pattern of top insurance executives to basically be gone from the home office this much? What is the normal practice?

Mr. GIULIANI. Let me——

Chairman NUNN. You have just said that he wasn't holding the subsidiary executives accountable. What was he doing when he was out all over the world about half the year?

Mr. GIULIANI. Mr. Gamble's view was he was responsible for the subsidiaries, and he had a particular interest in the international. In fact, in that division, the International Division, he was the CEO.

Chairman NUNN. But he wasn't holding them accountable.

Mr. GIULIANI. That is right; in my opinion, Senator.

Many of these trips were related to those subsidiaries. Not every one, but many of them were. The foreign ones I would say in every case, to my knowledge, were related to those overseas subsidiaries or businesses that they were involved with, because he was out dealing with prospects, customers, as the case may be, to develop, to continue to develop the business. He was leaving Blue Cross/Blue Shield for me to run.

Chairman NUNN. Do you think he was really working out there on all these trips?

Mr. GIULIANI. I assumed that he was. I certainly hope he was working.

Chairman NUNN. Dr. Duvall, as chairman of the board, did you know that the chief executive officer was gone about half the year?

Dr. DUVALL. I knew he was gone a lot, Senator. I didn't know—I wouldn't have guessed these numbers of days. You see, we were not there much of the time. The board meets every 2 months. There are the committee meetings. And he was actually at most of those things.

---

[1] See Exhibit No. 11 on page 270.

I knew he was gone a lot just from the CEO reports, reporting of trips.

Chairman NUNN. Well, looking back on it, how do you view your CEO being gone about half the time as chairman of the board?

Dr. DUVALL. Let me say two things, sir: One is, I think as Mr. Giuliani indicated, this became a very important thing to Mr. Gamble. My sense is he was working all the time, talking to people and lawyers and businessmen and stuff like that. I don't really think he——

Chairman NUNN. But he wasn't holding the subsidiaries accountable for management.

Dr. DUVALL. I know, but on these trips, he was doing business most of the time. I don't think he took his golf clubs and all that kind of stuff.

I forget the second part of the question. Oh, you had asked about——

Chairman NUNN. So even looking back on it, this doesn't bother you, then?

Dr. DUVALL. Well, yes, it does, in just the way it looks. I will tell you how it does bother me, Senator. I told Mr. Giuliani in the course of February and March during our then-frequent phone calls, before this whole thing with the board took shape, I said to Mr. Giuliani—who was by then the CEO designee, the inheritor CEO. We had already decided that as a separate discussion. I said, "Ben, I don't care how this all works out," and later I might have said, "with McKenzie. But I can tell you one thing. If we continue with all this international business, we are going to hire an international expert and have him do the flying around, because the CEO of GHMSI is going to be in downtown Washington at his desk." And you can ask Mr. Giuliani if that is correct.

Mr. GIULIANI. That is correct, sir.

Dr. DUVALL. And that is before McKenzie really got on board.

Chairman NUNN. But this had been going on, Doctor, while you were chairman for several years. This is not just a 1-year pattern. 1989, 1990, we could put all the charts up there, but you have seen them. There is no need to do that. This is a pattern of being gone half the time. And at the same time, one of the top executives working with him, Mr. Giuliani, says basically he wasn't holding the subsidiaries accountable, and that is what he was out there doing. So it just seems to me——

Dr. DUVALL. The basic matrix of the work that he was doing in all these red boxes had to do with the growth and business strategy of the various subsidiaries.

Chairman NUNN. Do you have a subsidiary in Venezuela?

Dr. DUVALL. I would have to defer detail on that.

Chairman NUNN. Do you have one in——

Mr. GIULIANI. No, sir, we do not. The International Division, however, has a lot of business throughout Latin America. And whether they were in Venezuela for existing customers or new, I couldn't tell you.

Chairman NUNN. How about Tokyo?

Mr. GIULIANI. Yes. Yasuda, I believe, is the name of the large insurer in Tokyo is a customer. What is the time frame? 1989? I don't know whether that was then a prospect or a customer.

Chairman NUNN. How about Singapore?

Mr. GIULIANI. Singapore, yes, there is an office. Maybe a subsidiary there was in Singapore, an office or subsidiary of the International Division, yes.

Chairman NUNN. Is that part of what you have gotten rid of?

Mr. GIULIANI. Yes. I would love to show you, Senator, what I have done.

Chairman NUNN. Are you going to be able to sell for a decent price? Anything like what you put in these subsidiaries, are you going to be able to get that price out of them?

Mr. GIULIANI. In some instances, I will admit, out of 45, not many. But in some, yes. We expect in one case this year to realize a very nice return. We just sold one in Paris. That is a done deal. We got a million-dollar gain out of it.

I would love to show you the chart about what I have done regarding subsidiaries because it has been consuming my life for 6 months, Senator.

Chairman NUNN. Okay. I will give you a chance before you leave.

Mr. GIULIANI. Thank you.

Chairman NUNN. Let me ask Dr. Duvall a couple more questions, and then I will get back and let you wrap it up.

Dr. Duvall, how much did the board get paid? How much did you get paid as chairman?

Dr. DUVALL. $800 a meeting, I think.

Chairman NUNN. $800 a meeting. Was that about, what, $10,000 a year approximately?

Dr. DUVALL. That was probably more—well, there were two boards—would you like me to get my notes on that?

Chairman NUNN. Just give me a range. We can fill in the record.

Dr. DUVALL. I suppose my total compensation was in excess of $25,000 based on running two boards and executive committees with board retainers and meetings. That was approximately twice what anyone else made.

Chairman NUNN. About how much a year?

Dr. DUVALL. I would say in the range of $25,000.

Chairman NUNN. Most people made about $10,000 or $12,000 a year, and you made about $25,000 as chairman.

Dr. DUVALL. Right.

Chairman NUNN. Last year you voted to increase your liability insurance; is that correct?

Dr. DUVALL. That is right.

Chairman NUNN. Why was that?

Dr. DUVALL. We felt it was woefully inadequate.

Chairman NUNN. Because of what factors?

Dr. DUVALL. That kind of thing was under continual scrutiny.

Chairman NUNN. How much had the liability insurance been, and what did you change it to?

Dr. DUVALL. It had been 10. I think it went to 15.

Chairman NUNN. Fifteen what?

Dr. DUVALL. Excuse me. It has been 10 million, and then I think we increased it to 15 million, which was collective for the entire board.

Chairman NUNN. That was for everybody, total?

Dr. DUVALL. That is the total package.

Chairman NUNN. Was there individual liability insurance, too?

Dr. DUVALL. No, sir.

Chairman NUNN. Did you get alarmed about what you were hearing about the company? Is that why you increased the liability insurance?

Dr. DUVALL. I suppose that was a factor.

Chairman NUNN. You began to think you might have some exposure?

Dr. DUVALL. Well, we were about the business of fixing things in an industrious and steadfast way. I don't think we have anything to be worried about at this point. And we have also decided to go ahead and try to see if we can work out an arrangement with Virginia.

Chairman NUNN. Dr. Duvall, the staff testified that on the Jamaica subsidiary between $300,000 and $500,000 of the initial $5 million investment was given to Blue Cross of Jamaica prior to signing an agreement in order to assist with their cash flow problem.

Did you know about this $300,000 to $500,000?

Dr. DUVALL. I have no recollection of that, Senator.

Chairman NUNN. You don't recall that?

Dr. DUVALL. No.

Chairman NUNN. Mr. Giuliani, you don't——

Dr. DUVALL. I would probably not have known about it.

Mr. GIULIANI. I am sorry?

Chairman NUNN. Do you know anything about that? $300,00 to $500,000 was give up front before any agreement was signed with Jamaica. Do you know anything about that big hunk of cash?

Mr. GIULIANI. Up front?

Chairman NUNN. Yes.

Mr. GIULIANI. No, sir.

Chairman NUNN. All right. What can you do with the Jamaica investment, Mr. Giuliani?

Mr. GIULIANI. The Jamaica plan is one of our 10 subsidiaries on our list for divesting in 1993. The name Blue Cross in Jamaica is critical to the survival of that organization, and, therefore, that limits the opportunities for us with respect to divesting ourselves. We must sell it to a not-for-profit organization.

We have made inquiries of certain other organizations. There is an organization in Jamaica, which that person is on the board of Jamaica Blue Cross, that does have a not-for-profit organization. So we really are in the middle of beginning to have discussions with a multiple number of individuals, perhaps, who may have an interest.

It is our thrust that we wish no longer, with respect to our new strategy, to be involved with Blue Cross of Jamaica, and we have just got to find our way to get out in a most effective way that we can relative to trying some way to preserve our $6.5 million investment, getting some return back for the sake of our subscribers. So that is one of the issues that is on our agenda.

Chairman NUNN. Dr. Duvall, let me wrap up my questions to you just by saying: Looking back, you have been on this board a long time. You obviously are a doctor. You have a substantial

amount of income. Looking at the amount of money you got from the board, certainly that money was not a big consideration, I would not think. Is that right?

Dr. DUVALL. It cost me money, Senator.

Chairman NUNN. I would imagine. Looking back, what do you think now are the duties of a board? What should the people who are policyholders out there expect of a board of trustees or board of directors of a non-profit organization like Blue Cross/Blue Shield?

Dr. DUVALL. I think that is an excellent question, and I guess it is going to be the kind of thing you are going to have to come to closure on. I can tell you as chairman of the board, if I had an office—I didn't have a parking place, even. But if I had an office with people with Alabama sweatshirts and about half of your staff, we wouldn't have been in this mess.

In other words, if it is the duty of a board to serve as an internal audit and a second-guess function on management, then the boards would have to be equipped with staff and auditors reporting directly to them.

Ours is a voluntary board, basically, if you will accept that rhetorically. We just weren't set up to do that. We relied on many consultants of all kinds. There were legal consultants. There were a variety of special consultants for various projects. We had three consultants in rapid succession inside of several months to determine executive compensation, something that has been, I think, somewhat unfairly criticized in the staff report. We had outside public auditors, and we had not one or two, but three regulators and an association.

If somebody had picked up the phone a while ago, maybe we wouldn't be in this mess.

Chairman NUNN. What do you——

Dr. DUVALL. And called me.

Chairman NUNN. What do you mean by that, if somebody had picked up the phone?

Dr. DUVALL. If I had heard about many of the things we have discussed in the course of this hearing, some segment of it from a credible witness or source, I think things could have turned out differently.

Some of the strategies, some of the considerations that drove strategy having to do with liquidity and reserve amounts, for example, were recurringly and permanently characterized as being unique to our plan. Mr. Giuliani explained that only 20 percent of our business was risk, or maybe at times it was more than that, and so we needed to drive our strategy to build these reserves which were not buildable in any other way.

I think if the board could have seen how other plans ranked through the association, they might have known earlier what I learned later, that we stick way out like a sore thumb in terms of liquidity. We are not even close, and we are scrambling to make that benchmark.

So I think better communications among these regulatory bodies to the board would be helpful. It would have been helpful, sir, if we had had a report of your Maryland and West Virginia findings. You explained in the beginning of this report how they started to set a pattern. If we had known that in July, perhaps that would

have helped some. I don't think it would have in that particular instance because we had already been doing this for months, and we were committed to being under way with what we had to do.

Chairman NUNN. But if you had known that 2 or 3 years earlier, it might have helped?

Dr. DUVALL. It might have helped, yes. So I think some——

Chairman NUNN. What advice would you offer to the board chairmen of Blue Cross/Blue Shield in another area of the country now? Having gone through what you have gone through, what would you say to them? Or what advice would you offer to your successor, Mr. O'Malley? We will be hearing from him in a few minutes.

Dr. DUVALL. I would think when there are the kind of salient and fundamental pieces of summary information, filings with commissioners and all sorts of things like that, I think the board ought to be copied on that. And then that would increase the information flow.

In an association like ours, I think the board could be recipient of more regular information.

Chairman NUNN. So you think when the regulators, like Commissioner Willis or Commissioner Foster, when they are communicating with the CEO's of the companies, you think the board, on important documents, should be copied?

Dr. DUVALL. I think so. And I think if there is a problem, I think a phone call would have been as much as I would have needed to look into it.

Chairman NUNN. But who would the call come from?

Dr. DUVALL. Whoever we are talking about. The regulator, like Mr. Foster. I mean, Mr. Foster was so upset with the data he was getting that he finally decreed it was unreliable, he testified yesterday.

Chairman NUNN. Right.

Dr. DUVALL. And it came to a point where the chief financial officer was not welcome in his office.

Chairman NUNN. Right.

Dr. DUVALL. And maybe other staff, too. I was not aware of that, Senator. That is a pretty strong position for him to take. And when Mr. Giuliani brought this question to my attention—I don't know when it was, like September or October—he had decided to make a change in the chief financial officer position. I fully supported that change based on what I just told you.

That came as a big surprise to the board, who had known the other gentleman and revered and respected and had respect for him over many, many years.

Chairman NUNN. Okay. Anything else you want to add?

Dr. DUVALL. I would say one further thing, just to get out of my current box a little bit, and ask you to imagine how this might have turned out differently with small market insurance reform, with return to community rating, with some substantive reforms of the health care system, which needs to be fixed. I think that would have preempted a lot of the scrambling we found ourselves having to do in a hyper-competitive marketplace where people had been just cherry-picking things right and left. There are many things that you can do, Senator, with the stroke of your pen. That curve

will get flatter with medical liability reform and a number of other things. I know you are about that business, and I wish you and Mrs. Clinton well.

Chairman NUNN. Well, she has got a big job. There is no doubt about that. The only thing I can do around here is make a speech. I don't have any pen that signs legislation, but I think that we all have a responsibility to work for reform in Medicare, Medicaid, and the whole array of health insurance and the whole coverage. There is no doubt about that.

But to get back to the point, the core business was profitable, and you lost your money on the extracurricular activities.

Dr. DUVALL. The game plan was contra that. The subs were to be the cash cow and help defray the cycles and to help our subscribers. And it didn't work out.

It is not working out for IBM. They are changing strategy as we speak.

Chairman NUNN. Well, we thank you for being here and for your cooperation.

Our final witness will be Mr. Peter O'Malley. Mr. Giuliani, I know you want to talk about what you are doing, and Mr. O'Malley is going to talk about some of his changes and plans. Why don't you wrap up, Mr. Giuliani, and then we will have Mr. O'Malley.

Mr. GIULIANI. Thank you, Senator.

Obviously, through the course of these discussions, you have heard about Mr. Gamble's diversification strategy, and this effort is to identify to you in 6 months what I have done insofar as what I inherited in late July, and to begin to implement immediately the future strategic direction of GHMSI, which is focusing on the core business and the need to support customers in this area.

I believe this is the chart that your staff had developed with respect to the 45 subsidiaries, and I think this was presented yesterday, if I recall. Is that correct?

Chairman NUNN. I believe that is the right chart, yes, sir.

Mr. GIULIANI. Okay. Thank you.

We then started a process to quickly deal with the biggest problem areas, and in my view, they were the overseas reinsurers. So we started there, and we have moved through focusing on a lot of the overseas—in fact, of the 24 subsidiaries that are no longer there, and I can show you a chart once they are gone, what is left—17 of those, if I recall, are the overseas foreign subsidiaries. There is only one left: BCJ, Blue Cross of Jamaica. And Blue Cross of Jamaica is on the list, as I said earlier in response to your earlier question, with respect to the actions that I plan to take during 1993 to divest ourselves of another 10 subsidiaries. So once we do that, that is what that chart reflects, which is then simply back to the core business, and only those subsidiaries needed to support that core business on a go-forth basis.

So that is where we have come from. By doing that, we have eliminated probably $25, $30 million dollars of costs associated with those divested, but in addition we have also reduced our own costs of those going forward by an equal amount.

Chairman NUNN. Have you got any amount of money that you have lost overall by reason of the difference between what you paid

for these subsidiaries and what you have received from them, plus your operating loss? Do you have that compiled anywhere?

Mr. GIULIANI. Insofar as those that we have liquidated?

Chairman NUNN. Those that you have liquidated.

Mr. GIULIANI. Those that we have liquidated, there are two that come to mind that resulted in revenues coming back to the organization: the one in Paris and the Assistant Service Division. The others were basically shut-down situations. Close the office, shut down the business, cancel the business, cut the losses, bring it back in within GHMSI, and we will manage it from there and get out.

So that is the thrust. I don't have a number, Senator, but that is the thrust we tried to do, focusing on the high losers first, and then moving on through.

We do have financial advisers that have helped us. We have a transaction that we are now in negotiations on regarding one of the 10. We plan to deal with this here. That would bring to the organization—that subsidiary has a net worth of around $5 million. We have the potential to sell that for between $15 and $20 million. So that is one which we are working with financial advisers to see if we can work our way through to get that to that kind of resolution, which would have a positive effect on the bottom line. And that is not in our business plan. The business plan assumed that subsidiary would make $2 million, so that would go but would be replaced by the gain on the sale of the subsidiary.

Chairman NUNN. Mr. Giuliani, looking back on your career, what would you do different? If you could unwind the last several years, what would you personally do that you didn't do to try to avoid this situation that your overall organization is in today?

Mr. GIULIANI. Knowing what I know now, Senator, I would have attempted to do whatever I could—questionable what that could have been, insofar as the end result—of not getting involved in the overseas international subsidiaries, frankly.

Mr. Gamble in his letter to me of November says, "One should not label the diversification strategy as a failure but, rather, as a significant accomplishment and a notable success."

I totally disagree, and those actions reflect what I have taken as a result of that. If we had never been there, never had undertaken—we did need some diversification relative to subsidiaries to support the core business, HMO, utilization review companies, et cetera. Some of those are appropriate. Had we focused, should have been focused on what we do here and only that. If we had not gotten into all the others, I am going to guess that our net worth would be substantially—you know, $75 million plus, $100 million, whatever it might be, greater than what it is today.

Chairman NUNN. What would you do about this attitude that seemed to be pervasive with the subsidiary organizations in terms of the money just flows from wherever you need it, that there is no real accountability here? What would you have done about that attitude?

Mr. GIULIANI. The same thing as I did when I first assumed responsibility: put controls over them, management and financial controls over their activities, stop them from entering any new arrangements, no new products could be developed.

Chairman NUNN. But that wasn't done with the subsidiaries. It was done with the core business only, right?

Mr. GIULIANI. No. When I took over in July of 1992, the first hour I made those announcements of things that had to be done. They were curtailed with respect to expenses as well as their activities, and they were brought under my type of management control.

Chairman NUNN. How do you view some of the expenses you have seen enumerated up there? Let's just say City Club memberships, the amount of money on entertaining, the amount of money spent on golf clubs, all of that. How do you view that in terms of your obligation to policyholders?

Mr. GIULIANI. Let me characterize it this way, Senator. Before, we talked about the corporate account. There was in the GHMSI corporate account, ball park, in the last 4, 5, or 6 years—I don't remember the exact amount—around $700,000 of first-class air travel, which included the Concorde.

In Blue Cross/Blue Shield, that corporate account had first-class air travel, 1989 to 1992, of $4,000. Total amount, total different attitude. There was no first-class air travel this year. So the attitude is totally different with respect to how funds are spent. And the way that GHMSI is operating today is the manner in which I believe that Blue Cross operated before, and now applied those same principles to the entire organization.

Chairman NUNN. Mr. Giuliani, how much money do you earn today?

Mr. GIULIANI. Today my salary is approximately $319,000.

Chairman NUNN. Is that less than it was in the past or were these other——

Mr. GIULIANI. Twenty-five percent less.

Chairman NUNN. When did you take that salary cut?

Mr. GIULIANI. In 1992. That salary, my compensation is composed of a base salary, which is what that number is just cited, and then an incentive package based upon results. And while I was entitled to an amount, I went to the board and told them, given our financial situation, I should not be paid any incentive amount.

Chairman NUNN. Was that $460,947 figure I have for your salary in 1991, was that including bonuses? That is total compensation?

Mr. GIULIANI. Incentives, yes, sir.

Chairman NUNN. And so you are saying in 1992 you are making less than you did in 1991, overall total compensation?

Mr. GIULIANI. And I still am making that.

Chairman NUNN. How about the other executives? Are they making less or have they been raised? What have they been given?

Mr. GIULIANI. A lot of them are gone, Senator. Insofar as the GHMSI subsidiary heads, only one of those received any incentive dollars. Everyone else received no incentive dollars.

Among the moves we have made is to freeze salaries; no increases in base salary, for example, sir.

Chairman NUNN. What is your incentive plan in general description? How do you measure incentive pay in this field?

Mr. GIULIANI. It was arranged for by outside consultants, and let me describe it because I am more familiar with the way Blue Cross/Blue Shield worked.

The primary issue was financial results, bottom line for Blue Cross/Blue Shield. Other elements were how we did regarding the budget. Did we come in under budget? Also, how we did with respect to marketing results, projected new revenue less cancellations.

So you had some corporate objectives which made up a part of the incentive plan, and then a division head would have some more specifics regarding the performance of that division. So they were all based upon predetermined, within the business plan, projected results, the marketing, cost, bottom line. Those were the basis of incentive payments to be made, and we will continue to have, whenever we have incentive payments programs again, that kind of program.

Chairman NUNN. Yesterday Mr. Robert Willis, who is the D.C. insurance superintendent, testified he is working on legislation and regulations to enable him to properly regulate GHMSI. Mr. Willis said that as an interim measure he will ask the organization to sign a consent agreement to fill the short-term gap in the regulation of the company.

Have you seen any agreement of that nature yet?

Mr. GIULIANI. No, sir. No, sir. We have really developed a fine respect for Mr. Willis. I saw his testimony yesterday, for example, about consent order. We have been under a consent order since August, so that would be fine. We are certainly willing to cooperate in any way we can.

Chairman NUNN. You have been under a consent order in which jurisdiction?

Mr. GIULIANI. Virginia.

Chairman NUNN. Virginia. What are your plans? What can you tell us about your plans for possible merger?

Mr. GIULIANI. As I said earlier, that is in very sensitive negotiations. They have been constructive, positive. It is moving forward. We have another meeting coming up soon—Friday, I believe—to continue that dialogue. And I think, frankly, whether it be now or in the future, I think the Blue Cross/Blue Shield plans around the country of which there are 72, 73, must consolidate, get in to 7 to 10 regional organizations. So I think that is the future of Blue Cross/Blue Shield so we can more effectively serve our customers.

Chairman NUNN. Mr. Giuliani, I am going to call up Mr. O'Malley. If you don't mind just taking a seat and waiting, I may have another question for you and I may not. But if you don't mind just waiting until we have Mr. O'Malley's testimony.

Mr. GIULIANI. Thank you, Senator.

Chairman NUNN. Did you get through with everything you wanted to say this morning?

Dr. DUVALL. Yes, sir.

Chairman NUNN. Thank you.

Our final witness today will be Mr. Peter O'Malley. Mr. O'Malley is the recently elected chairman of the board of trustees for GHMSI.

We appreciate your being here, Mr. O'Malley. We swear in all the witnesses before the Subcommittee, so I will ask you to hold up your right hand. Do you swear the testimony you give before the

Subcommittee will be the truth, the whole truth, and nothing but the truth, so help you God?

Mr. O'MALLEY. I do.

Chairman NUNN. Mr. O'Malley, I don't know whether you have a statement this morning or not, but we would be pleased to have one. I believe you took over as chairman, and you can give us the date of that and proceed as you would like.

TESTIMONY OF PETER F. O'MALLEY,[1] CHAIRMAN OF THE BOARD OF TRUSTEES, GROUP HOSPITALIZATION AND MEDICAL SERVICES, INC.

Mr. O'MALLEY. I do have a statement, Senator, if you would permit.

Mr. Chairman, members of the Subcommittee, my name is Peter O'Malley. On October 1, 1992, I accepted the invitation of the board of trustees of Group Hospitalization and Medical Services, Inc., to join it as the chairman. It was intended by me, and by the board, to be for a limited time to assist during a period of transition.

I take my board responsibilities very seriously and was reluctant to undertake that assignment because of other commitments in my professional life. Initially, I recommended that the board consider other candidates, and I suggested several individuals. At the urging of the board and Ben Giuliani, chief executive officer-elect, and after being assured that the board would remain fully involved and that reforms I had earlier proposed had or were about to become a reality, I accepted the challenge. The charge accompanying that challenge, however, was far different from the task at hand.

In my discussions with the board and Mr. Giuliani, three primary areas of responsibility were identified for the position for which I was being solicited. First, I would provide leadership in communicating with and preparing the board for the sweeping changes then under way. In addition, I would assume responsibility for regulatory matters. Finally, I would supervise the company's cooperation in connection with the inquiry of this honorable Subcommittee. My assumption of these duties would allow Mr. Giuliani to focus entirely on the operations and the restructuring of GHMSI, matters to which he and the board were firmly committed.

Within days of assuming my responsibilities, and following visits to the Virginia Insurance Commissioner and from the Blue Cross/Blue Shield National Association, it became clear that the subsidiary losses had severely impacted GHMSI's ability to meet the requirements of both the Virginia insurance commissioner and the National Association.

The Virginia insurance commissioner advised me of his concern about GHMSI's position with regard to the Virginia regulatory reserve requirements. Likewise, the National Association had placed GHMSI on its watch list and had threatened action which went to the core of the company's ability to do business.

This information was promptly shared with the entire board. Needless to say, in view of the significance and complexity of these

[1] The prepared statement of Mr. O'Malley appears on page 264.

issues, efforts to resolve them have required a virtual around-the-clock commitment.

Almost simultaneously, Dr. Duvall advised me of a call from Mr. Norwood Davis, CEO of the Blue Cross and Blue Shield Plan of Virginia, inquiring whether there was merit to discussing an affiliation with the Virginia and National Capital Area plans. During the initial visits, we learned that a similar proposal regarding regional affiliation had been explored several years earlier.

Given the apparent benefits of the concept, particularly the subscriber benefits and cost reductions, this development, too, was immediately reported to the board. After its thorough discussion with Mr. Davis regarding financial capability, organizational culture, and commitment to subscribers' interest, the board of trustees authorized the necessary due diligence to evaluation an affiliation.

This, too, has been a taxing exercise. Everyone connected with GHMSI has worked exhaustively to understand and evaluate the consequences of this proposal and its impact on our mission to serve subscribers as the insurer of last resort in the metropolitan D.C. area.

Concurrently, as you have heard, Mr. Giuliani and senior management were successful in eliminating 24 of GHMSI's 45 subsidiaries and in conducting the evaluation process which promises to lead to the sale or elimination of 10 more subs so that GHMSI's focus will return to the core business. The board has remained fully informed of, and diligently engaged in, this effort.

This process has required tremendous effort on the part of many dedicated people at GHMSI. They all have worked very hard to achieve the critical goals and to follow the clear present direction from management.

Externally, however, the view is less clear. As the Subcommittee is aware, this hearing is taking place in the midst of sensitive discussions between GHMSI and Blue Cross and Blue Shield of Virginia regarding the mentioned affiliation. The marketplace is attuned and volatile. Capital and time are our most precious and limited assets. Significantly, the traditional sources of capital are not readily available to non-stock, non-profit entities such as GHMSI, and the regulators control the time we have to work towards a solution.

Mindful of these factors, the board and senior management have been working intensely in connection with the proposed affiliation. Their purpose has been to identify and understand the consequences of the transaction so that it will be structured in a manner which will not only be in the best interest of subscribers, employees, and providers, but will also win the necessary approval of GHMSI's multiple regulators.

While such issues persist, I can report that our discussions with Virginia are in a constructive phase, and we are hopeful that an affiliation can move forward on a sound business basis. If we succeed, GHMSI, Blue Cross and Blue Shield of Virginia, the National Association, and the cooperating regulators will have much to be proud of. As GHMSI continues with its restructuring and pursues the affiliation, it has at least $90 million in cash and Government and corporate securities and $300 million set aside on its balance sheet to cover unpaid claims.

Affiliation is not a certainty. We, therefore, have been working simultaneously on a program to assure continued service to our subscribers. This also will require continued cooperation from the regulators to whom GHMSI must answer.

We have chosen at every stage to attempt to accommodate the needs of those regulators and to involve them in the process. In Virginia, with the assistance of the National Association, we achieved a temporary solution to the need to maintain our reserve levels in an amount equal to 45 days' worth of claims by obtaining a $15 million surplus note from the National Association. Additionally, we purchase reinsurance for our Virginia business at a cost to GHMSI of approximately $2.8 million.

GHMSI must chart a course for the future that is not only honorable but realistic. Obviously, the Virginia affiliation is a very promising opportunity. If, however, that transaction cannot be accomplished, or cannot be accomplished promptly, GHMSI must be prepared to well serve subscribers' needs through other means. To that end, GHMSI's senior management has developed, and the Board has approved, a comprehensive business plan for 1993 and beyond.

The business plan reflects the advice of numerous talented consultants and our new energetic chief financial officer. It calls for the continuing divestiture of those subsidiaries which are not directly related to our core Blue Cross and Blue Shield business. The business plan further emphasizes the previously recognized need to cut costs and expenses. It projects revenues in 1993 of $1.7 billion and a resulting increase in statutory reserves of $13.6 million.

Chairman NUNN. Mr. O'Malley, let me ask you a question on that particular point. The business plan that was submitted to our staff recently showed a reduction in statutory reserves of about $5 million, and now basically this is showing an increase projected of $13.6 million. Can you explain those different figures?

Mr. O'MALLEY. No, sir; unless it is 2 different documents. With your approval, I would like to turn to our chief financial officer and get his assistance.

Chairman NUNN. Is he here?

Mr. O'MALLEY. Yes.

Chairman NUNN. If you could introduce yourself, we will swear you in before you testify.

Mr. O'MALLEY. He could advise me, if you would be satisfied, Senator, or tell you directly, as your preference.

Chairman NUNN. Well, we will just have him testify.

Do you swear the testimony you give before the Subcommittee will be the truth, the whole truth, and nothing but the truth, so help you God?

Mr. WARD. I do.

Chairman NUNN. Maybe you could give us your name and official title.

Mr. WARD. My name is David Ward. I am the acting chief financial officer for GHMSI.

I do not have the documents in front of me. I believe that the reduction in the reserves is a result of the anticipated repayment of the surplus note to the Blue Cross/Blue Shield Association. The

operating results for 1993 project an increase from operations of $13.6 million in the reserve position.

Chairman NUNN. But when you pay back the loan, you are really going to have a net decrease of $5 million.

Mr. WARD. That is correct. There will be a net decrease when the loan is paid back to the Blue Cross/Blue Shield Association. It is treated today as subordinated surplus in our reserve position.

Chairman NUNN. Okay. Go ahead, Mr. O'Malley.

Mr. O'MALLEY. GHMSI's self-examination process, in combination with focused management, the sound advice the board has received from its superior consultants, and the board's firm resolve to follow that advice, all suggest that the future can belong to GHMSI.

Costs and expenses have been sharply reduced; unnecessary and underperforming subsidiaries have been or will shortly be sold or eliminated. The adventuresome, unfocused corporate culture depicted in the staff's historical analysis certainly no longer exists. Progress has been made.

Since assuming my responsibilities, at the board's direction and on its behalf, I have emphasized the needs of subscribers, employees, and providers. We have continuously stressed the importance of integrity, accuracy, and speed in dealing with the informational needs of our regulators and this Subcommittee.

Over the last 4 months, with the board's strong encouragement, the internal restructuring at GHMSI and the related effort to gain control of costs and expenses is on track. Things are on the mend. Intense, continuous attention is being focused on the important challenges with which we are confronted. Priorities have been established and are being strictly adhered to.

GHMSI's often painful self-examination, performed under the spotlight generated by this Subcommittee—appropriately, I might add—has shaken the institution to its core. Mr. Chairman, the Subcommittee can be assured that the board and current management are committed to honoring the requirements of GHMSI's charter and to ensure that the company well serves this community. Surely this deserves being worked through to success.

Thank you, Senator.

Chairman NUNN. Thank you, Mr. O'Malley. Just a few questions.

You have got $15 million that has been infused in terms of a loan from the national organization, National Blue Cross and Blue Shield; is that correct?

Mr. O'MALLEY. That is correct, Senator.

Chairman NUNN. Now, what are the terms of that? When is that money supposed to be paid back?

Mr. O'MALLEY. We are obligated to pay it back by February.

Chairman NUNN. February of 1993?

Mr. O'MALLEY. This year.

Chairman NUNN. This year. Where is the money going to come from to pay that back?

Mr. O'MALLEY. The money, that $15 million, is segregated and has been kept in a reserve account. In order to pay it back, it will require the approval, under the terms of the consent decree, of the Virginia insurance commissioner.

There is a provision, though. I have been regularly advised by the National Association that they will not extend this loan. There is a provision for them, if they conclude we are making progress, to extend it.

Chairman NUNN. Suppose Virginia says that they will not let this money be paid out of reserves and the national says they want their money back, then what do you do?

Mr. O'MALLEY. The agreement acknowledges the regulator's supremacy.

Chairman NUNN. Do you know yourself whether the national derived their funds——

Mr. O'MALLEY. I have been advised by Mr. Tresnowski that it was advance payments on dues.

Chairman NUNN. On dues. So, basically, they are taking it out of their operating funds?

Mr. O'MALLEY. That's my understanding, Senator.

Chairman NUNN. Do you have any prospects for further cash infusions from the national association?

Mr. O'MALLEY. The discussions involving the Virginia affiliation have fully included the national association and alternatives consider their involvement.

Chairman NUNN. Are you talking merger right now with Virginia? I understand you are, is that right?

Mr. O'MALLEY. We have chosen the term affiliation, Senator.

Chairman NUNN. Affiliation?

Mr. O'MALLEY. Yes.

Chairman NUNN. And what is the prognosis on that?

Mr. O'MALLEY. As I mentioned in my statement, and as Mr. Giuliani observed before me, constructive due diligence has been extensive. The original discussions starting with Dr. Duvall, Norwood Davis and myself were in the first week of October. We projected a 30-day diligence period. Frankly, the diligence revealed a number of issues that required extensive investigation. We extended the diligence period for 60 days.

I would say we are reasonably close to completion of the diligence. We are now at the circumstance where the business deal has to be structured in a fashion that is fair to all parties, meets any fairness test and that would withstand the test of the regulators and their different perspectives.

Chairman NUNN. Are you talking to any alternative prospect, either purchases or people that you might be affiliating with or merging with?

Mr. O'MALLEY. We continue to explore opportunities, but I think it would be inaccurate to characterize there being any active discussion with an alternative——

Chairman NUNN. Are you open to other offers, if people are interested?

Mr. O'MALLEY. If you turn to your TV cameras, Senator, I would put up my 800 number. [Laughter.]

Chairman NUNN. Good. If you have got the number, go right ahead. [Laughter.]

So you would be open to other offers?

Mr. O'MALLEY. We would encourage them, and Mr. Davis of the Virginia Plan understands that, has been appreciative of that and

has not in any way discouraged. In fact, in a recent conversation shared with me, he offered to make certain due diligence that he obtained at his company's expense available to a prospective alternative, which I think was very generous and helpful.

Chairman NUNN. Mr. O'Malley, is your job now a full-time job as chairman?

Mr. O'MALLEY. Substantially beyond, Senator. The agreement that I entered into with Mr. Giuliani used the term "substantially full-time," because I did not want to be in the technical breach if I honored preexisting commitments. Circumstances develop that, quite frankly, it has been six and a half or seven days around the clock, I have been fully available 24 hours a day to the leadership of Blue Cross-Blue Shield and to its board.

Chairman NUNN. What is your salary and compensation arrangement?

Mr. O'MALLEY. The board authorized $375,000. I chose to accept $345,000, to indicate a willingness to set the way for a reduction that was going to be in store for other officers. Based on an annual figure of $345,000, it was intended, at least by me, that I not serve out the year and, therefore, it would be substantially reduced. Candidly, Senator, I chose to take a commensurate reduction from my law firm existing income due me, with a calculation done that if I left at the time I intended to from Blue Cross-Blue Shield, it would have come out a wash.

Chairman NUNN. Are you continuing with your law firm? Are you still a member?

Mr. O'MALLEY. I am of counsel to the firm and occasionally call them or accept calls from them, but, frankly, they haven't seen me much in 90 days.

Chairman NUNN. Is there any kind of conflict of interest that you see between continuing to practice law and being full-time chairman?

Mr. O'MALLEY. None at all, Senator. I first examined the firm's case list and assured myself that there was none with the firm, and I am extremely careful about any client contact. Frankly, I have talked to one client in 120 days, and that late one evening involving an historical matter that I had handled for them a number of years ago. I am not a partner in the firm. I cam counsel to the firm.

Chairman NUNN. How many years were you on the board, Mr. O'Malley, before you came back this time?

Mr. O'MALLEY. Three.

Chairman NUNN. Three years. What years were those?

Mr. O'MALLEY. 1986, 1987 and 1988.

Chairman NUNN. During that time, there were a lot of these decisions about going abroad and investing in international companies. Do you recall what was discussed in the board when you were there?

Mr. O'MALLEY. My recollection would have been hazy until the last several weeks. I have sat and re-read most of the minutes, all of the minutes from 1983 to date. I have myself pretty well refreshed, yes.

Chairman NUNN. Were these ventures into subsidiary investments and credit backups and so forth discussed thoroughly at board meetings?

Mr. O'MALLEY. I would choose the word "extensively," perhaps more than thoroughly. When I came on the board, it was March of 1986. The notion to diversify had de jure been substantially in place, though the formal motion, as I recall, was not until late in 1988.

Clearly, Mr. Gamble had decided strongly and forcefully that the alternatives to the historical cyclical swings that the core business faced, that alternatives had to be found. He was messianic in his belief that it was a—and I believe be truly felt that this was a correct and forward-thinking visionary way to solve the health care problems of the future. he was committed to that force and regularly advanced it with enthusiasm and skill.

Chairman NUNN. Looking back on it, do you think mistakes were made by the board while you served on the board?

Mr. O'MALLEY. I sat in the audience and I heard the discussion on diligence, Senator, and I thought to myself that there is a semantical distinction here. I think I heard a medically trained, conscientious, sincere man talk about vigilance and synonymous with diligence, and I think I hear the Chairman of the Subcommittee talking about diligence in the sophisticated term that is used in the business world and doing the necessary term of art "due diligence" to assure one's self that the business is seriously and knowledgeably undertaken.

I look back on the board at that time and, in reading the minutes, it refreshed me on the makeup of the board. As I say, there were 3 to 5 or so people, I believe that is the correct number, with a plan to get to 25. I really can't think of one that didn't impress me as conscientious. I can't think of one that wasn't sincere of purpose and thought that they were involved in some form of public service.

Frankly, they had widely varying perspectives. It wasn't long after I was on the board—and I was invited on the board with another gentleman, and we went to an orientation together, and it was suggested that we were asked on the board because of our experience in the business community and because of our geographical locations.

The other gentleman, after several meetings, decided that this was not something he found interesting or that he could make a contribution to. We discussed it. I cam close to joining him in leaving, but concluded that I had made a commitment to serve out a term, perhaps the contribution I could make would be to improve the style and nature of the proceedings, to impose some helpful business guidance on it, and I set about doing that.

I am sure your staff has shown you the exit interview I did when I left the board in my last meeting and those items that I suggested should occur, including an outside consultant, including reducing the size of the board, including bringing in business people, preferably a partner from a Big Eight law firm.

Chairman NUNN. Who did you make those suggestions to?

Mr. O'MALLEY. The entire board.

Chairman NUNN. At a board meeting?

Mr. O'MALLEY. Yes, my last board meeting, the last item of business, I asked for the opportunity to make some suggestions.

Chairman NUNN. Did you basically serve out your term, or did you leave early?

Mr. O'MALLEY. No, I completed my term. I had made a commitment.

Chairman NUNN. Were you asked to stay on?

Mr. O'MALLEY. They discussed it with me and I chose to accept—Senator, I have got pretty extensive involvement with nonprofit boards. It has been a personal commitment since shortly after I got out of law school. I generally try to serve on one at all times. I chose to accept another nonprofit assignment, rather than accept reappointment to this. It was a polite way to disassociate.

Chairman NUNN. I believe the March 8, 1988 board meeting minutes reflect that certain presentations were made and you had certain concerns. Do you recall that particular meeting relating to lines of credit, prior year projections, results and so forth of various subsidiaries?

Mr. O'MALLEY. I am not certain about the exact date. I recall being disturbed that the—again, the 1986, 1987, 1988 time period, 1986 was largely an educational period for me. This was a new field, this was an activity where I needed to learn the terminology and the language, I needed to learn the dynamics of the board, learn the names of the members of the board. It was a learning experience.

1986 figures came in and they were on 1985's accomplishments, and they were outstanding. They were extraordinary. The reserves hit an all-time high, income was at an all-time high, so there was a high comfort zone. The following year, the projections didn't match. After that, the projections didn't match, and I think the meeting you are referring to is I asked that we receive not only future projections, but historical evidence of what the projections had been and where the shortfalls were coming.

Chairman NUNN. Did you get that information?

Mr. O'MALLEY. I recall that it was promised for a meeting in the future and, as I sit here, I don't recall. I would have to go back and check the minutes again.

Chairman NUNN. Was Dr. Ferguson the individual that came on the board with you that left?

Mr. O'MALLEY. No.

Chairman NUNN. Or was he someone else who was on the board who——

Mr. O'MALLEY. It was another gentleman. It was not a physician.

Chairman NUNN. Do you remember anything about his retirement letter, where he stated that it bothered him to see an organization losing millions of dollars and yet supporting for-profit ventures?

Mr. O'MALLEY. I do recall it and I thought there was accuracy to it. I also thought it pointed out something else. And I am sure the staff has shared with you one of my comments in the exit interview or my last meeting—I termed it an exit interview—was that I thought the board had a divided culture and that one of the things it needed to do was come to grips with whether it was a nonprofit enterprise pursuing the core business, or whether it was committed

to the ventures that required a different level of skill and a different approach to minding its business.

The physicians historically—this is my opinion, now, but while I saw at those board meetings, I found them equally conscientious to the non-physicians, but naturally of the perspective involving medical payments, procedures that would be approved, attitudes of the medical society, human and natural concerns from their perspective.

I understood the letter to be sincere, genuine, a worthy warning, but also from a perspective, an historical perspective of one who preferred the core business.

Chairman NUNN. Mr. O'Malley, do you recall any discussion about Jamaica, discussing that specifically in the board?

Mr. O'MALLEY. Yes, I do.

Chairman NUNN. Can you give us the nature of that discussion?

Mr. O'MALLEY. My involvement or the discussion?

Chairman NUNN. Just the discussion that took place with the board.

Mr. O'MALLEY. The presentation, as I recall it, was by Mr. Gamble and it was presented in the context and tone of a sterling opportunity, a unique bargain, if you will, a chance to advance the mission, the diversification mission, and in a sense to do well by doing good, because at the same time it would be helping another Blue plan. Substantial discussion occurred.

A very persistent physician, a commendably persistent physician over the years inquired about the wisdom of that transaction, about the instances of unrest that could occur. At that point, I chose to use that particular issue to focus the dichotomy within the board and said that we needed to come to grips with was this consistent with a strategic plan, did the board have a strategic plan. If it was consistent with the strategic plan, then we had to know whether we were going to go forward with it, and the then CEO had to know that his recommendations, if followed, would cause him to be accountable based on results.

Chairman NUNN. Do you recall any discussion about whether the money could be repatriated, if you made a profit, or whether you could recoup your investment under Jamaica laws? Was that ever discussed?

Mr. O'MALLEY. I can't say it wasn't, but I have no recollection as I sit here.

Chairman NUNN. You heard the testimony, I don't know whether you heard all of it yesterday, but you heard some of it repeated today about the amount of money spent on expenses, on first-class air fare, on Concordes, on entertainment and so forth, a lot of club memberships, and all of this adds up to an awful lot of money. Looking back on it or even looking forward, from both perspectives, what do you see that went wrong in this kind of management, and what do you believe was the responsibility of the board of trustees regarding those kinds of expenditures?

Mr. O'MALLEY. Candidly, Senator, I can give you the obvious answer that they are shocking expenditures. But of the various nonprofit educational boards and foundations that I have served on over the years, I do not recall an instance where the travel expenses were reviewed by the board.

Now, obviously, there was no—I am talking outside Blue Cross and Blue Shield. You obviously serve in many capacities yourself, and perhaps your experience is different. But I did sit down and go through systematically the list of boards that I have served on, and I do not know of one where the board reviews travel expenses.

Chairman NUNN. How about entertainment?

Mr. O'MALLEY. Nor do I know of one here the travel expenses anywhere near approached the magnitude of what is here.

Chairman NUNN. How about board policy, though? Do you think boards have a responsibility to lay down some kind of policy about entertainment expenses and travel expenses? Did you hear about flying 130 or 140 people out to Monterey, California? Did you hear about all the expenses all around the world?

Mr. O'MALLEY. Yes, I have before the hearing and as a description of what occurred yesterday. I think spending policies need to exist within limits. Candidly, Senator, I think organizations reflect the top. George Fritz Steinbrenner runs the Yankees, and that is what you see.

Years ago, I was in professional sports and I believe the person that told me this is a neighbor of yours, Tommy Cousins. He told me that it was his observation—we were at a National Hockey League meeting—that sports organizations always reflect the leader, and he pointed out certain people around the table and their personality became the personality of the team that they led. And from that he observed that he thought that was true in business. That was 15 or 20 years ago that he told me that. I have carried that with me and I believe that is true. I think the culture here reflected the leader. I think in the last 3 months, we have a new leader and a new culture.

Chairman NUNN. What about the board now, do you think the board is going to have a policy on expenses?

Mr. O'MALLEY. The board is in the process of being advised by very skillful counsel on its fiduciary responsibilities, standards of conduct, procedures that it should follow.

Additionally, we are asking our new chief financial officer and our outside auditor to give us a standard reporting system, a mechanism of red flags that will go off, should there be a failure to appreciate the responsibilities of this enterprise. The board is totally supportive of it.

The day that I attended my first meeting, and all of the officers of the company joined us at the board level and on behalf of the board, I issued the instruction that total, complete candor, total integrity, without regard as to the consequence, would be the order of the day, any violation would be immediate termination. That has been the tone and mood of the board going forward, and I don't think there will be any deviation. You have their attention.

Chairman NUNN. Do you have any other comments, Mr. O'Malley?

Mr. O'MALLEY. No, sir, beyond saying that I think we have a circumstance that is akin to a traditional business turn-around. That is frankly one of the reasons that attracted me to this. I was asked to take on the turn-around assignment for a financial institution simultaneously with this invitation. I chose this one. I chose this one, because of the opportunity or impact on the region. I think we

can salvage this. I think the subscribers will be protected. I think the exercise will be worthwhile. I hope you will continue to use your good offices to encourage the regulators to join with Commissioner Willis in his efforts for a regional approach.

Chairman NUNN. Thank you very much. We may have questions for the record to you, Mr. O'Malley, and we may have some also, Mr. Giuliani, to the company.[1]

Thank you for being here.

Mr. O'MALLEY. Thank you, sir.

Chairman NUNN. Thank you all very much.

The Subcommittee is adjourned.

[Whereupon, at 12:25 p.m., the Subcommittee adjourned.]

[1] See Exhibit 123.b. on page 531.

APPENDIX

STAFF STATEMENT

U.S. SENATE PERMANENT SUBCOMMITTEE ON INVESTIGATIONS

HEARINGS ON OVERSIGHT OF THE INSURANCE INDUSTRY: BLUE CROSS AND BLUE SHIELD—NATIONAL CAPITAL AREA

JANUARY 26, 1993

I. INTRODUCTION

Mr. Chairman and members of the Subcommittee, today the Subcommittee continues its inquiry into the ability of State regulators to oversee the operations of the 72 Blue Cross and Blue Shield insurance plans that provide health care coverage to almost 95 million Americans. Today's hearing is the fourth in a series that are intended to examine allegations of misconduct and mismanagement on the part of a number of the Plans, as well as difficulties that State regulators have encountered in attempting to safeguard the interests of the policyholders.

As you know, this inquiry arose as part of the Subcommittee's overall investigation of fraud and abuse in the insurance industry, which has been ongoing now for 2 years. During the course of that investigation, a number of insurance regulators informed the Staff of problems they had encountered with regulating their Blue Cross/Blue Shield Plans. Many noted they spent a disproportionately greater amount of time regulating their "not-for-profit Blues" than they did on any "for-profit" insurance companies. Other regulators indicated that they knew little about their Blue Cross/Blue Shield Plans, and that when they attempted to find out more about their operations, they were either denied access or otherwise barred by their own State law from requiring full disclosure.

Many of these regulators believed that the operations, management style, and corporate philosophy of "the Blues" had shifted over the last decade. Regulators and other health care experts expressed concern that the original purpose which had guided the Blues for most of the last 50 years had substantially changed to the detriment of the subscribers.

On July 2, 1992, the Subcommittee held its first hearing on this topic, at which time it received testimony from two distinguished regulators—the Honorable John A. Donaho, Insurance Commissioner for the State of Maryland; and the Honorable Robert M. Willis, Superintendent of Insurance for the District of Columbia. These regulators described the many difficulties they countered in attempting to oversee the Blue Cross Plans operating within their jurisdictions. In addition, the Staff presented an overview of some of the specific problem areas which we were discovering during the initial stages of our inquiry. At that hearing, Mr. Chairman, you set out a blueprint of the issues that would guide future hearings. These issues included:

—The financial integrity of the Blue Cross/Blue Shield Plans;

—The proper role of the National Blue Cross/Blue Shield Association in ensuring its members Plans are financially sound and well managed;

—The propriety of not-for-profit Blue Cross/Blue Shield Plans creating and operating "for-profit" subsidiaries, and the impact these subsidiaries or affiliates may have on the financial integrity of the "not-for-profit" parent Blue Cross/Blue Shield Plans;

—The effectiveness of State regulators in overseeing their domiciled Blue Cross/Blue Shield Plans and affiliates;

—The management style and philosophy of the Plans, and whether these have become inimical to State regulation;

—The propriety of the salaries and fringe benefits of the officers and directors of some of these Plans; and

—The overall role of the Federal Government in monitoring and supervising the Federal programs administered by the various Blue Cross/Blue Shield Plans.

On July 29 and 30, 1992, the Subcommittee held its second hearing and examined the circumstances surrounding the failure of the Blue Cross/Blue Shield Plan of West Virginia. In October, 1990, the West Virginia Plan became the first Blue Cross/Blue Shield Plan ever to be placed in liquidation receivership. As a result of the failure of the West Virginia Plan, over 51,000 individuals were left with unpaid claims; and thousands more saw their coverage cut back, canceled, or put out of their reach by tremendous increases in premiums.

The Staff's investigation of the West Virginia failure revealed that many of the issues which the Chairman had outlined at our initial hearing appeared to be contributing factors to the demise of the West Virginia Plan. These factors included:

—Mismanagement by the senior officers of the Plan;

—Lax and inadequate oversight of management policies and activities by the Board of Directors;

—Diversion of management and Plan resources and attention to non-Plan related activities;

—Conflicts of interest by senior management and the Chairman of the Board;

—Creation of subsidiaries and affiliates for the personal gain of certain officers and members of the Board of Directors; and

—Inadequate regulation of the Plan by the West Virginia Department of Insurance.

At the Subcommittee's July 2nd hearing, the Maryland Insurance Commissioner had leveled a number of disturbing allegations against Blue Cross/Blue Shield of Maryland (BCBSM). In response to these serious charges, the Chairman directed that the Staff investigate how BCBSM was operated and how well the State insurance regulators had been able to oversee these operations. On September 26 and 27, 1992, the Subcommittee examined the operations and regulation of the Blue Cross/Blue Shield Plan of Maryland. That Plan, which was started in 1937, insured approximately 1.4 million Marylanders, or close to 30 percent of the State's population.

Although the limited amount of time available to the Staff prevented an exhaustive inquiry, the Staff did find, much to its consternation, that many of the factors which contributed to the demise of the West Virginia Blue Cross/Blue Shield Plan were present, in varying degrees, in the Maryland Blue Cross/Blue Shield Plan. Moreover, all of the allegations raised by the Maryland Insurance Commissioner were valid. The Staff found that, as was the case in West Virginia, the Maryland Plan was beset by:

—Questionable management decisions;

—Questionable financial practices;

—Unprofitable subsidiaries which have been a drain on Plan assets and resources;

—Diversion of management and Plan resources to some non-health insurance or non-health care related subsidiary activities;

—Inadequate oversight of the Plan by the State insurance regulator;

—Questionable spending on matters not directly benefiting providers or subscribers; and

—A poor level of service to providers, subscribers, and the general public.

Since those hearings, a number of events have occurred that are relevant to the Subcommittee's ongoing inquiry. As a result of our hearing, the Maryland Hospital Association commissioned its own review of the Plan. We have been advised that all of the findings of the Subcommittee were confirmed by the Maryland Hospital Asso-

ciation. A copy of the letter from the Maryland Hospital Association will be made part of the hearing record today.

In addition, within a week of our hearing, the Board of Directors of the Maryland Plan initiated their own review of our allegations and also ultimately confirmed the Subcommittee's findings. A copy of a letter from Frank A. Gunther, the new Chairman of the Board, which details the results of their review will also be made part of the hearing record.

Since our September 24th and 25th hearings, a number of steps have been taken by the Maryland Plan's Board of Directors in response to the problems the Subcommittee identified and in an attempt to improve the Maryland Plan's condition. Among these actions, they included:

—On October 8th, the Board removed Carl Sardegna as Chairman and replaced him with retired businessman, Frank A. Gunther;

—On October 22nd, the Board canceled bonuses for top executives, the Plan's annual Preakness hospitality tents, membership in exclusive golf clubs and other establishments, and put the Plan's sky box at Oriole Park in the Camden Yards up for sale;

—On November 16th, the Board announced that 11 subsidiaries would be disbanded by the end of 1992 and reduced the value of two of its health maintenance organizations (HMO's) by $10 million;

—On November 19th, the Board acknowledged, as previously identified by the Subcommittee, that approximately $88 million of the $102 million it had listed as reserves did not conform to standard accounting rules but was, rather, allowed by special permission of the State regulators;

—On November 19th, the Board accepted the dismissal of three top executives and asked another to accept reassignment. With the retirement in 1993 of Fred Gloth, the Plan's senior counsel, four of the six top-paid officers will be gone by spring;

—On December 4th, the Board forced the resignation of Carl Sardegna, the President, CEO, and former Chairman of the Board of the Plan; and

—On December 5th, the Board cut its own salaries and monthly fees in half. The Board also announced that it was "shocked" at the amount spent on outside consultants and affirmed they were canceling bonuses for top officials and reviewing the six-figure salaries of corporate officers.

The Staff would also note that the Board of Directors of the Maryland Plan have now admitted publicly that they were not fully apprised of many of the actions that had been taken by Mr. Sardegna, the former President/CEO, and his management team. For example, in his letter to the Subcommittee, Mr. Gunther acknowledges that although they knew the bottom-line financial condition of the company, ". . . the method of presenting the results was always 'spun' to highlight the positive and ignore the negative." Concerning the Plan's poor provider and consumer service record, Mr. Gunther now admits that, the Board ". . . was not aware that the problem was as acute as it is."

The most critical area that Mr. Sardegna and the former management failed to apprise the Board about dealt with problems that the National Blue Cross/Blue Shield Association had with the finances and management of the Maryland Plan. In his letter, Mr. Gunther states that:

> Of most concern to the Board members was the fact that *until the second week in November*, when I received a copy of a letter from the Blue Cross and Blue Shield Association regarding their monitoring of the Blue Cross of Maryland, *the Board was not aware* that Mr. Sardegna had submitted a plan to the Association to improve the company's surplus, liquidity and service with specific goals and timeframes. While we had been told that the Association was monitoring Blue Cross, *we were led to believe that that monitoring was business as usual. We were not aware of the specifics of the plan of recovery with the Association or even that it existed.* [Emphasis added.]

The Staff has been advised by reliable sources that the discovery by the Board of this apparent deception on the part of Mr. Sardegna was the ultimate act that led to his "resignation." The Staff has also been told that the Board only became aware of potential problems with the National Association after being alerted to this possibility by the Maryland Insurance Department. The Insurance Department, in turn, had only become aware of the full extent of the National Association's dealings with Mr. Sardegna shortly before, when their staff reviewed, pursuant to U.S. Senate res-

olution, certain material from the National Association that had been subpoenaed by this Subcommittee and made part of the sealed record of its Maryland hearings.

Apparently, not only had the Maryland Plan's Board been kept in the dark by Mr. Sardegna and the National Association, but the Maryland Insurance Department, which had ultimate regulatory responsibility for protecting the interests of the Maryland subscribers, had not been adequately advised. This development confirms earlier criticisms leveled by the Subcommittee Staff at the manner in which the National Blue Cross/Blue Shield Association coordinates its activities with State regulators and the individual Plans' Boards of Directors.

This morning, the Staff is prepared to report on its review of the activities of another Blue Cross and Blue Shield Plan: Group Hospitalization and Medical Services, Inc., dba Blue Cross and Blue Shield of the National Capital Area, hereinafter, the DC Plan. On the basis of its 6-month investigation, the Staff has found that many of the problems identified in the West Virginia and Maryland Plans are present in the DC Plan.

The Staff found the following serious problems with the management and operations of the DC Plan:

—Inadequate oversight of management activities by the Board of Trustees;

—Inadequate or non-existent oversight of the Plan by State regulators;

—A history of unsound management decisions by the senior officers of the Plan and its Board of Trustees;

—A proliferation of unprofitable subsidiaries and other business ventures that placed a critical drain on the finances and management of the Plan;

—Wildly excessive expenditures by senior officers and the Board, with no apparent benefit to the Plan or its subscribers; and

—An apparent unwillingness or inability on the part of the National Blue Cross/Blue Shield Association to monitor, control, and prevent management inadequacies and excesses by the Plan's senior officers and Board of Trustees.

In our review of the West Virginia Plan, the Subcommittee was confronted with conducting the post mortem on a Plan that had died approximately 18 months before our first hearing. In the case of Maryland, the Staff found a live but sickly insurer that could and probably will survive if corrective actions are quickly taken by its Board and State regulator.

Today, the Subcommittee is confronted with what some have called a critically ill patient. A profligate life style on behalf of its senior management and Board have left it financially destitute. The Staff does not know if the DC Plan will survive. Nearly everyone the Staff has interviewed has opined that it is seriously ill. The Staff's own review clearly indicates this dire situation. Recent financial data provided this month to the Staff show losses of $38.8 million for 1992, which are substantially worse than the $2.4 million profit the Plan had previously forecast. Projections for the future are uncertain and are contingent on external capital infusions.

However, the Staff is aware that management has recently undertaken radical surgery to cease international operations, to eliminate losing subsidiaries, and to cut operational costs. It is our hope that drastic actions such as these and other therapies that will be discussed during the course of this hearing may actually bring the patient back from his sick bed.

Regardless, the Staff believes that the troubles it has uncovered raise an additional question that goes beyond the tragedy of the three Blue Cross and Blue Shield Plans we have examined. Namely, are the problems of mismanagement and failed oversight by the Board and regulators endemic to the entire health insurance system? If so, then our Nation may be confronting something far more serious than the illness of a few Plans. With that question in mind, the Subcommittee Staff presents the following analysis of the DC Plan.

II. BACKGROUND

Today, Group Hospitalization and Medical Services, Incorporated, serves over one million Blue Cross and Blue Shield subscribers in the District of Columbia, Prince Georges and Montgomery Counties in Maryland, and Arlington, Alexandria and part of Fairfax County in Virginia. The corporation has annual revenues in excess of $1.5 billion, and employs over 3,300 people. In 1991, the Plan ranked 13th out of 73 in terms of annual premium income.

Group Hospitalization, Inc. (GHI) was originally founded as a hospitalization prepayment program on November 15, 1933. However, in 1939, due to the D.C. Insurance Department's requirement that GHI become a stock or mutual insurance com-

pany so that it could be subject to the same regulations and taxation as a commercial insurance company, the United States Congress passed an act authorizing GHI to operate only for the benefit of its subscribers and not for profit, and exempted it from D.C. Insurance Department regulation.

In 1942, the American Hospital Association authorized GHI to use the Blue Cross service mark; and in 1951, the Board of Trustees authorized full participation in the Blue Cross system.

Medical Service of the District of Columbia (MSDC) was incorporated in 1948 and began offering prepaid coverage for limited physician's services to all employees who had contracts with GHI. Meanwhile, GHI promoted, marketed, and administered MSDC. MSDC became affiliated with the Blue Shield system in 1948, and in 1952 MSDC was authorized to use the Blue Shield service mark. The two companies were co-located; and, until the two merged, MSDC had maintained a separate Board of Trustees, medical advisory structure, executive management, and claims processing, as well as other functions.

In 1984, following hearings before the Subcommittee on Fiscal Affairs and Health and the Committee on the District of Columbia of the House of Representatives, the United States Congress amended GHI's Congressional charter, merging GHI and MSDC into Group Hospitalization and Medical Services, Inc. (GHMSI). The newly formed GHMSI retained its Blue Cross and Blue Shield affiliations and adopted the trade name Blue Cross and Blue Shield of the National Capital Area (BCBSNCA).

In granting them their new charter, Congress again enunciated the purpose of GHMSI, as well as the responsibility of its management and Board of Directors. In section 3, it states:

> Sec. 3. Said corporation shall not be conducted for profit, but shall be conducted for the benefit of the aforesaid certificate holders. The business and affairs of this corporation shall be conducted by its board of trustees, who shall have full power and authority in the premises, including authority to provide for all expenses incident to the conduct and management of its business and affairs. . . .

In the 1984 amendment to the Congressional charter, GHMSI continued to enjoy the exemption from insurance regulation by the District of Columbia. In addition, Congress granted GHMSI the authority ". . . to engage in any lawful business that is incidental to or supportive of the business and affairs of this corporation."

As a result of this change in phraseology, GHMSI's Board and management rapidly spun off for-profit subsidiary companies and plunged into the international insurance industry. It was this subsidiary growth that many now say was responsible for the majority of the Plan's current losses. A chart prepared by the Staff and attached to this statement as Appendix A depicts this subsidiary growth.

In 1988, significant changes were made to the internal corporate structure. BCBSNCA became an unincorporated division of GHMSI, and two of GHMSI's subsidiaries were included in that division. Management of GHMSI's other subsidiaries were then internally organized into six divisions or groups.

In 1991, GHMSI's structure was expanded to eight divisions and groups. These eight divisions and groups are as follows: the Insurance Group; the Assistance Services Group; the International Division; the Association and Special Risk Division; the Health Management Services Division; the Third Party Administrative Division; BCBSNCA; and Blue Cross of Jamaica. The subsidiaries reported to Division heads as depicted in Appendix B, which is attached.

As of December, 1992, there were a total of 45 wholly owned and majority-owned or controlled subsidiaries that were designated to the eight divisions and groups. Each subsidiary is headed by a Chief Executive Officer (CEO) or Chief Operating Officer (COO) and has its own Board. An organizational chart (Appendix C) depicts the December, 1992, structure of the GHMSI "enterprise." A description of each subsidiary provided by GHMSI will be made part of the Subcommittee's hearing record.

A fact of significant concern for the Staff is that while the Plan's Board included outside parties, the Board of Directors of the subsidiaries consisted of the Plan's managers. In fact, the Plan's former President, Joseph Gamble, served as the Chairman of the Board of almost every subsidiary. (See Appendix D.) The Staff strongly believes that this contributed to the absence of external oversight of the 45 subsidiaries.

Although the Staff will review in greater detail many of the most important subsidiaries of the Plan, it is important to note that the proliferation of subsidiaries was sudden—the bulk occurring from 1985 to 1989. In addition, the Staff notes that some of these subsidiaries were even created as late as 1992, some even after the

Subcommittee launched its investigation of the Plan. For example, World Access Europe was created on August 1, 1992, and World Access New Zealand was created on July 1, 1992.

Since the Subcommittee's investigation started in July, the Plan has initiated a significant departure from its previous expansion. After the creation of those two subsidiaries, the Plan publicly announced their intention to sell, close, or otherwise dispose of many of the subsidiaries. We have learned that the Plan's "new" management is scrambling to reorganize yet again. Now, however, the focus is on the "return to basics," that is, concentration on its original purpose—to provide low-cost health insurance to the citizens of the Washington Metropolitan area.

III. FINANCIAL HISTORY

A. *Solvency*

The Staff has extensively reviewed financial data related to GHMSI since its creation in 1985. This review shows that during that period it incurred losses in all but 3 of the 8 years—1985, 1989, and 1990. More significantly, the net loss for this period was approximately $182 million.

A review of the Plan's audited statements using Generally Accepted Accounting Principles (GAAP) show net income for the year ended December 31, 1985, of about $25 million. This is followed by large net losses for 1986, 1987, and 1988 of approximately $42 million, $66 million, and $58 million, respectively. These are followed by net income of about $2 million in 1989, and $3 million in 1990. For the year ended December 31, 1991, there was a net loss of approximately $7 million reported.

Two weeks ago, the Plan provided the Subcommittee Staff with the projected financial results on a GAAP basis for 1992. These showed overall losses of $38.8 million, which were substantially worse than the original forecast of a $2.4 gain. For 1992, the Plan forecasts operational losses of $18.7 million, with additional "future loss contingencies" of $20.1 million from subsidiaries. The following table lists the losses by years:

GHMSI (Consolidated)

Net Income (Loss)—GAAP Basis

Year	(In millions)
1985	$25.2
1986	($42.5)
1987	($66.5)
1988	($57.7)
1989	$1.9
1990	$3.1
1991	($7.2)
1992 (projected)	($38.8)
Total	-($182.5)

As Appendix E reflects, the Plan's reserves (or net worth) as reported on a GAAP basis is projected to drastically decline to a negative balance, as of December 31, 1992, of -$25.1 million. This reserve had been reported on a GAAP basis at over $180 million on December 31, 1985. It subsequently dipped to less than $16 million at the end of 1988, and then increased to approximately $24 million by the end of 1989 and 1990. The reserve shown as of December 31, 1991, was a little over $32 million. Thus, within a year, from 1991 to 1992, the reserve fell from a positive $32 million to a negative $25.1 million—approximately $57 million.

Records from the Plan indicate that the number of subscribers (for BCBSNCA only) increased slightly from almost 1.1 million at the end of 1985 to over 1.2 million in 1991. The Staff's review also indicates that from 1985 to 1991, the Plan's premium income from its core business increased from $808 million to $1.5 billion. Thus, even with this dramatic increase in premium income, the Plan still lost money. Certainly some of this is a attributed to higher medical costs, but our investigation disclosed significant losses attributed to unwise management decisions and questionable expenditures.

In reviewing the financial data for the last few years, the Staff noted that the subsidiaries were a constant drain on the company. For example, the 1992 projected financial results (GAAP) show that the BCBSNCA core business and CapitalCare showed a positive operating result of approximately $8.1 million. Yet, the Plan's reserves were reduced by almost $50 million in losses from its subsidiaries. These 1992 losses include $5.5 million from the Assistance Group; $6.7 million from the International Group; $1.5 million from the National Capital Administrative Services (NCAS); $19.1 million from the Insurance Group; $14 million from Protocol; and $2.3 million from EMTRUST.

A review of the 1991 financial data shows a similar drain on the core profits of the Plan. In that year, Blue Cross and Blue Shield of the National Capital Area (BCBSNCA) reported net income of over $14 million. But that was completely offset by a loss of over $14 million from the Assistance Group alone, consisting of Access America and the World Access operations. In addition, the International Division incurred losses of almost $2 million; Protocol almost $5 million; and National Capital Administrative Services and Blue Cross of Jamaica almost a million each.

For 1990, BCBSNCA reported earned income in excess of $16 million which, again, was offset by net losses of almost $13 million from the Assistance Group, and losses of almost a million dollars each by NCAS, Blue Cross of Jamaica, and the National Capital Insurance Agency (NCIA).

In 1989, BCBSNCA reported net income of about nine and a half million, which was offset by losses of $2.5 million from NCAS; $2 million from Health Management Services (HMS); almost $2 million from Blue Cross Jamaica; and almost a million dollars each from CapitalCare and Protocol.

GHMSI's "Reserve for Protection of Subscribers" declined from over $180 million as of December 31, 1985, to a projected deficit of $25 million as of December 31, 1992, under Generally Accepted Accounting Principles (GAAP). The Statutory Accounting Principles (SAP) reserve for December 31, 1992, is estimated to be $48.4 million. However, the reserve calculation under SAP includes a $15 million note from the National Association, which is due to be paid back next month (February, 1993) and the appraised market value of $73 million for the GHMSI building and real estate. According to National Association officials, only one other Plan was afforded the opportunity to carry its headquarters building at market value. Without this $15 million note and the excess of the appraised value over cost of the building, the Plan would also have a negative reserve under SAP of over $30 million.

GHMSI's reserves have fallen so dramatically primarily due to poor financial results of extensive national and international subsidiary operations. Cumulative losses from subsidiaries over the years have amounted to over $100 million. As of September 30, 1992, GHMSI has guaranteed almost $28 million in lines of credit, $26 million of which is outstanding. These lines of credit are guaranteed by $42 million of GHMSI's marketable securities.

The following are additional highlights of the Staff's review of the Plan's finances. This review consisted of internal and external audits, audit workpapers and memoranda, and other financial and operating performance data prepared by the Plan, its consultants, the National Association, and various insurance regulators.

B. *Liabilities Not Reported*

GHMSI has not historically reported a liability for vacation accruals and commission guarantees. As of December 31, 1992, GHMSI has a $6.8 million liability for vacation time earned by their employees. Price Waterhouse, the independent auditors, recommended in their 1989 management letter to GHMSI officials that they accrue a liability for vacation earned. However, GHMSI did not report this. The Staff has been advised that this liability will need to be reported for SAP, which will reduce their reserves reported to the insurance commissioners.

An additional liability historically not reported concerns a contract the Corporation entered into with B'nai B'rith to underwrite or arrange for the underwriting of a variety of health, life, and disability polices for its members. Under the terms of the agreement, GHMSI is obligated to pay B'nai B'rith no less than $2 million in total commissions for each calender year of the contract. This agreement may be terminated upon 2 years' written notice. Since it appears that a liability has occurred and is reasonably estimated at approximately $4 million, a liability should be established which will reduce reserves accordingly. This is only a small part of the overall losses the Plan will incur as a result of the B'nai B'rith contract.

C. *Blue Cross of Jamaica*

GHMSI gained control of Blue Cross of Jamaica in 1987 by investing a $5 million "surplus note," which has subsequently been increased to $6 million. During 1992, GHMSI forgave $0.5 million owed in intercompany transactions. For audits in 1990

and 1991, Blue Cross of Jamaica received qualified opinions from their independent accountants because of a breakdown in internal controls. In 1990, GHMSI's internal audit department performed a full-scope audit of Blue Cross of Jamaica. The audit disclosed numerous significant findings and concluded that ". . . there are areas of the Plan where procedures and controls cannot be relied on." The Staff has determined that there has been no written documentation of the "note," and none of it has been paid back or reimbursed due to the weak financial condition of BCJ. This, in itself, causes some concern to the Staff. It is the Staff's understanding that the note has been written down to zero in 1992 on both a GAAP and an SAP basis.

D. *Real Estate*

The Staff found that the entire SAP reserve for GHMSI is secured solely by the appraised value of its real estate, which consists primarily of its headquarters. Under GAAP, GHMSI's real estate has been recorded at its cost. It also had been reported on a similar basis for SAP purposes to the various insurance regulators. However, in 1989, the Virginia Bureau of Insurance allowed GHMSI to report the real estate at its market value. The headquarters building was appraised on December 2, 1991, at $90 million, which increased the SAP reserves by the amount of the increase from its original cost basis of $8.4 million. According to the Blue Cross National office, there was only one other Plan permitted to value its real estate at the appraised value.

1991 was the first year Price Waterhouse audited GHMSI's SAP statements and gave an unqualified opinion. The building was reappraised a few months later, and, due to a decrease in real estate values in Washington, D.C., the appraised value fell to $68 million. Price Waterhouse reissued their report footnoting that the reappraisal would result in a $22 million decrease in SAP reserves and unassigned funds.

E. *Postretirement Benefits Other than Pensions*

In 1993, the Staff has determined that GHMSI will be faced with a new and significant liability which will have an effect on its reserves. Beginning January 1, 1993, the Financial Accounting Standards Board (FASB) rule number 106 requires employers to accrue a liability for postretirement benefits other than pensions. Under GAAP, GHMSI has estimated a liability for these benefits in the range of $25 million to $42 million. The Corporation does have the option of amortizing the full liability over a 20-year period.

F. *Acquisition of First Continental Life*

On April 17, 1992, GHMSI closed on the purchase of First Continental Life and Accident Insurance Company of Utah. GHMSI purchased this insurance company, which is licensed in 43 States, as a platform to offer products in other jurisdictions. The sale was effective as of January 1, 1992, and GHMSI paid approximately $6.1 million plus a percentage of gross premiums written on business fronted by the seller for a 2-year period. The purchase included approximately $2.8 million of goodwill and intangible assets and will have a negative impact on the Corporation's 1992 reserves. Further, because GHMSI has committed to paying commissions to the seller in future years, they will not be able to expense those costs, resulting in an increase in non-admitted assets.

G. *Problems with Reinsurance*

During the Staff's investigation, several problems with reinsurance agreements were found. GHMSI's reinsurance program was administered without a qualified reinsurance manager. During 1991, GHMSI reported reinsurance premiums ceded of $45.8 million and reinsurance premiums assumed of $20.4 million. The reinsurance program was conducted without the benefit of controls or periodic audits. The reinsurance agreements were not approved by the Board. GHMSI has had a very difficult time attempting to identify all of their reinsurance agreements to the Subcommittee. GHMSI had reinsurance agreements in foreign languages without the benefit of certified English translation. GHMSI also had agreements that were not in writing between the International Division and the Insurance Division. As a result, GHMSI lacks the necessary controls to accurately measure the financial impact of the reinsurance agreements. The State of Virginia has been unable to determine under what authority the Plan assumed reinsurance. The regulators are scrutinizing the legality of these transactions.

H. *Contra Income Account*

GHMSI and BCBSNCA use normal expense accounts to record coach airfare and a special account called the "Corporate Account" to record the excess airfare for first-class and supersonic travel. However, when GHMSI compiles their annual and quarterly financial statements, GHMSI does not report the Corporate Account as part of expenses but, rather, as "income" in the form of a "Miscellaneous Income:

contra account." During calendar year 1991, GHMSI charged almost $300,000 to this account. The Staff believes this abnormal exercise in "creative accounting" should have been accounted for as an expense, not as negative income.

I. *Risky Investments*

The Staff found that up to 1992, GHMSI had taken unusual risks with subscribers' funds by placing up to 51.8 percent of its investment portfolio in equity securities. The average equity investment by other Blue Cross/Blue Shield Plans during this time frame was 15.1 percent. Although equities bring, for the most part, higher returns, they also carry the risk of greater losses caused by fluctuations in the marketplace. A market downturn could have caused the loss of a substantial portion of GHMSI's reserves.

Charles Duvall, former Chairman of the Board, told the Staff that it was the investment portfolio, equities in particular, which staved off financial ruin for GHMSI. However, the Staff notes that a market downturn could also have produced financial ruin for GHMSI by decimating their investment portfolio.

The Staff has learned that the Virginia Insurance Department also had problems with these investments and, as part of the August 3, 1992, Consent Order, required the Plan to take steps to reduce the Plan's over-reliance on these reserves.

As a result of the Consent Order, GHMSI's investment portfolio significantly changed. Equity stocks now account for 8.4 percent of the portfolio; secure, fixed-income securities account for 36.1 percent; and cash or cash equivalent securities account for 53.8 percent, or $58 million of the portfolio. The Staff is satisfied that the current investment regime is in the best interest of the subscribers and is a satisfying departure from former, more risk-laden practices.

IV. SUBSIDIARIES, DIVISIONS AND AFFILIATES

As previously mentioned, the Plan's venture into its far-flung subsidiary operations has been its chief financial nemesis. The Plan entered these unchartered waters in earnest on July 1, 1983, with the purchase of 51 percent of World Access, Inc., a travel assistance corporation owned by Dr. Sol Edelstein, a physician employed at the George Washington University Medical Center who had received some publicity as being in charge of the emergency room when President Reagan was shot in 1981.

Prior to 1983, only two subsidiaries, GHI Nominee (which held the title to the headquarters building for legal purposes) and National Capital Insurance Agency, Inc., existed. By August, 1992, the management of the Plan had embarked upon what one former Plan executive has called, a "frenzy of investments" in subsidiary operations with the creation of 45 separate legal entities—few of which had any relationship to the business of providing health insurance to the citizens of the District of Columbia, Virginia, and Maryland.

A former senior executive with the Plan contacted our office after he had left in disgust with the direction that the senior officers of the Plan had taken. He told the Staff that:

> It is interesting to note that the local Blues Plan was chartered by the U.S. Congress to provide affordable health care coverage to area residents. The Board and Senior management decisions to go off and create far-flung subsidiaries does not seem to comply with the Plan's original charter. It comes as no surprise that client insurance premiums were skyrocketing at a time when this Plan was off in waters where it had no business being, such as Protocol, World Access, Emtrust, Professional Office Services, and bidding on business that had very little if anything to do with their primary mission.

In a Board of Trustees meeting on May 20, 1983, Mr. Gamble outlined an aggressive program of international and domestic diversification. The Board minutes reflect:

> He stated that the Company's success would depend not only on GHI's ability to compete with commercial health insurance carriers, but on GHI's ability to diversify into new markets which would benefit GHI's subscribers. . . .
>
> He explained that the health insurance market, which is GHI's primary market, is unpredictable, yet highly competitive. Mr. Gamble said that the market with its present cost trends did not offer GHI the certainty of long-term financial viability. He stated that GHI needed to identify and develop

new markets and new products which would help stabilize the Company's long-term financial future.

As the years progressed, this strategy, which was approved by the Board of Trustees, would pull the GHMSI ship far from the safety of its core business and into new, more dangerous international and domestic waters. As explained to the Subcommittee Staff, the underlining justification of management for such a venture was to prepare for the inevitable downturn in the core insurance business as a result of increased competition from commercial insurers and the usual cycle of increased claims payments which occur approximately every 3 years.

Ironically, this diversification strategy, which was meant to stave off a financial downturn, has actually been one of the major contributors to the Plan's current financial ruin, costing the Plan over $100 million.

It should be noted that not all of the subsidiaries and affiliate operations were unprofitable and poorly managed. However, these were definitely the exception and not the rule. In the course of its review of the Plan, the Staff identified several key factors which contributed to the general dismal performance of most GHMSI subsidiary and affiliate operations. They are:

—Inadequate analysis was done before a subsidiary operation was created. In some cases, there was limited or no "due diligence" examinations made before sizable financial and human resources were committed to the development of a particular subsidiary or line of business. The Plan did not know even the most basic elements:

—Did any market exist for the product?

—What price should be charged?

—What regulatory environment existed?

—What were the pitfalls?

—Instead of capitalizing most of the start-up companies, the Plan subsidiaries borrowed money from financial institutions. The Plan guaranteed the debt, further committing the Plan's reserves to future, unknown liabilities.

—Until very recently, there was seldom a point when subsidiaries were independently assessed relative to their profitability and overall value to GHMSI or how the particular venture benefited the subscribers of this Congressionally chartered Plan.

—After the companies were created, management concerned itself solely with revenue, and never with mounting liabilities, rising overhead, and losses. Rosy and unrealistic projections were presented by senior management to the Board of Trustees which tended to focus on growth and revenue generation without explaining the downside of negative returns on investment or Plan equity. According to Charles Duvall, former Chairman of the Board, management assured the Board that profits were always just around the corner.

—Many subsidiaries were ventures in which the management had no suitable experience. As one executive told the Staff, "They flew by the seat of their pants and utilized the deep pockets of GHMSI to support their exuberant inexperience." The Staff found this to be particularly true for a number of the Plan's ill-conceived ventures in the international marketplace.

—No matter how poorly managed or unprofitable a subsidiary, the subsidiary operated with the attitude that it could always rely on continued funding from GHMSI. There appeared to be no real accountability on the part of the subsidiaries' management, since "the Plan would bail us out." In part, this is reflected in a number of the financial statements for subsidiaries, where the auditors added an explanatory paragraph stating that the continued life of a subsidiary depended on the financial backing of GHMSI.

—One Board member told the Staff that the subsidiary losses did not create an atmosphere of concern or panic, because BCBS managers and Board members are so used to seeing red ink on financial statements. It appears the Board was conditioned by years of up and down business cycles, and failed to realize the loss cycle for the subsidiaries never ended.

—It appears that some of the subsidiaries were often used as the private "playgrounds" of senior managers. Expensive world trips, dramatic growth in management and their salaries, conflicts of interest were found by the Staff to permeate the subsidiary environment. As one former executive told the Staff, there were always "frequent junket trips to the United Kingdom, Virgin Islands and

elsewhere outside the United States under the guise of trying to develop new product lines."

—Subsidiaries shifted the focus of Management and the Board's attention from the core insurance business, which was profitable, to these peripheral business ventures.

—The unique regulatory environment in which GHMSI operated prevented adequate oversight of its far-flung subsidiary operations. The Staff found that the Plan intentionally did not report to the various regulators and to the National Blue Cross Association accurate financial information on its subsidiary operations. The Plan argued that this was beyond the scope of their core business and, therefore, not relevant to outside scrutiny. The Staff found that only recently did regulators and the National Association finally come to appreciate the enormity of the subsidiary losses and its true impact upon the viability of the Plan as a whole.

An analysis supporting these observations is presented in the following section. In it, the Staff describes the details of the major subsidiary and affiliate operations and the significant problems that now confront the Plan.

A. *Blue Cross of Jamaica*

The Plan's investment of a total of $6.5 million in Blue Cross of Jamaica (BCJ) is one of the best examples of financial and other problems that have beset the Plan as a result of its diversification strategy. The Staff found that this significant investment was done with little prior due diligence to determine either the safety of the investment or the probability of any potential profits. Moreover, as far as the Staff was able to determine, neither the DC Plan's management nor it's Board ever calculated how, if it all, this endeavor would benefit the subscribers of the DC Plan.

BCJ was incorporated on December 26, 1956, in Jamaica and employs 140 people. It is the largest health insurer in Jamaica, providing health benefits for 180,000 residents.

It became affiliated with GHMSI on July 24, 1987 (with the actual contract signed on August 14, 1987). This affiliation involved GHMSI's providing the Jamaican Plan, which was in financial difficulties, with a $5,000,000 cash infusion in return for a controlling number of seats (eight) on the Jamaican Board. BCJ's financial difficulties resulted from increases in construction costs on their new headquarters building and the co-located commercial and residential complex that the Jamaican Government required them to build. The Government of Jamaica wanted the land developed in return for giving permission for the construction of the BCJ headquarters building in what was traditionally a residential neighborhood.

Mr. Gamble was the Chairman of the Board of the Jamaican Plan from July, 1987, until his retirement when he was replaced by Ben Giuliani. Mr. Hylton O. McIntosh was the President from 1983 to March, 1990, and was instrumental in the merger of the BCJ with the DC Plan. Currently, Dr. Henry Lowe serves as the President of BCJ. Dr. Lowe had formerly served on its Board of Directors from February, 1989, before becoming the President in August, 1990.

Upon discovering this investment, the Staff attempted to determine the motivation for such a departure beyond the traditional service area of the DC Plan. In particular, the Staff attempted to determine how such an investment would benefit the subscribers of the Washington Metropolitan area, who were, in effect, paying their premiums to prop up a Jamaican Blue Cross Plan.

Apparently the motive for this investment had nothing to do with benefiting the American subscribers. The GHMSI—Jamaican involvement, in the words of Mr. Gamble, came as a result of a need to "help another Blue Cross Plan out," not specifically to benefit the DC Plan.

According to interviews with former and current senior management of BCJ and Patrick Taylor, the Jamaican Superintendent of Insurance, the affiliation came about quickly. McIntosh, the former President, was notified by the Superintendent of Insurance in mid-1987 that they were in financial trouble and needed to find a solution. McIntosh told the Staff that he called Bernard Tresnowski of the Blue Cross and Blue Shield Association and informed him of his problems. He then set about searching for assistance from other BCBS Plans.

After calling several Plans including Ontario Blue Cross, and finding no one willing or able to help him financially, he called Mr. Gamble at BCBSNCA. Gamble told McIntosh it was difficult to discuss this matter over the phone and arranged a meeting for the very next day. Gamble's desire to expand manifested itself in his meeting with McIntosh at the Miami airport the next day to discuss how BCBSNCA could assist BCJ.

Gamble indicated in an interview with the Subcommittee Staff that the addition of BCJ to his expanding list of subsidiaries "fit naturally into [his] strategic plan for international growth." His only reference to the DC Plan subscribers occurred when he observed that a lot of his subscribers and other American Blue Cross subscribers vacationed in Jamaica and could possibly benefit from the service.

The Staff found that the Plan's problems with the Jamaican affiliation directly stem from the failure to perform an appropriate due diligence examination of BCJ prior to the capital infusion of $5,000,000 in July, 1987. Following the meeting in Miami, GHMSI requested documents from BCJ for review prior to the affiliation. But it does not appear any in-depth on-site inspection was done by GHMSI prior to the infusion of cash. Price Waterhouse, GHMSI's external auditors, Faxed a limited request for financial review to Price Waterhouse in Jamaica on July 6, 1987, and required a response on July 8, 1987. With less than 48 hours to reply, Price Waterhouse Jamaica reviewed the published financials of BCJ and spoke with Peat Marwick, BCJ's auditors at the time, about significant changes in BCJ's financials. They were not asked to do any further analysis, include researching prior management letters written by Peat Marwick which outlined numerous, significant problems, in the areas of accounts receivables and bank reconciliations, two key areas in any company's financial structure. Had Price Waterhouse Jamaica been asked to do further analysis or given more time, many of GHMSI's management problems with the Jamaican Plan may have been avoided.

The July 14, 1987, BCBSNCA Board of Trustees Meeting minutes reflect Gamble telling the Board he sent a draft agreement to McIntosh on July 8, 1987, the same day the Price Waterhouse report was due from Jamaica. The Staff seriously doubts whether BCBSNCA management and the Board would have had the time to review this report at all, let alone study the results, before voting to provide BCJ with $5 million.

The Staff does not understand the need to rush through this due diligence in light of the size of the investment. While BCJ was in financial difficulty due to loans incurred through unanticipated increases in building and construction costs on its new headquarters complex, certainly arrangements could have been made with the Jamaican Superintendent of Insurance to delay any regulatory actions while a serious offer was formulated.

Not only did GHMSI not ask for additional time, it appears that it even provided between $300,000 and $500,000 of its initial $5,000,000 investment before signing the formal affiliation contract. It is clear though, that BCBSNCA did not understand the situation they were entering, particularly Jamaica's economic and regulatory situation and the resultant problems these would cause GHMSI. While GHMSI provided assistance to BCJ immediately, it was not until 1990, 3 years after GHMSI's initial investment, that an in-depth audit was conducted by the DC Plan's internal audit staff.

That report made 58 specific findings and revealed gross mismanagement and questionable legal practices by the former President, former Vice President of Finance, and other former and current employees. That December 31, 1990, audit also questioned the basic internal controls of the Jamaican Plan, as well as the financial data concerning its operations and found:

> [T]here are areas of the Plan (Jamaica) where procedures and controls cannot be relied on. There are many additional procedures and controls that need to be implemented, . . .

A copy of that audit report will be made part of the Subcommittee's hearing record. However, in order to understand the serious problems that the DC Plan overlooked before investing their subscribers' money in this venture, listed below are a number of the more serious allegations made by the auditors:

—potential fraud against the Jamaican Government by overstating accounts receivables and membership enrollments on a Jamaican Government employee contract;

—no reconciliation of billings and payments, and no adequate recording of premiums;

—the entire accounts receivable system was "out of control," according to its manager;

—senior management created "a secret account" and ran approximately $100,000 per year through it for questionable purposes, including

(1) bogus overseas travel documentation was regularly prepared for senior management and others, which was used to file false vouchers;

(2) a tax avoidance scheme was created to hide from 20 percent to 35 percent of the top four officers' salaries from Jamaican taxes; and

(3) another tax avoidance scheme on behalf of five senior officers permitted them to set aside approximately $37,000 in salary as "personal allowances" to avoid its taxation as personal income;

—when auditors tried to interview an individual who worked closely with the former Vice President of Finance on this secret account, the individual disappeared and failed to show up for work for the 3 weeks that the auditors were in country (During a staff interview, she could not recall being absent for 3 weeks during the audit, but this was later confirmed);

—there were no written provisions or adequate supporting documents for the travel of senior management and Board members;

—there was no control over the company's credit cards, and the former CEO's credit card was still in effect even though he had left 6 months before the audit;

—a direct conflict of interest with the former President of the Jamaican Plan whose firm was the primary contractor for the Plan's condominium development, its only significant asset; and

—a number of instances of the company being used by senior officers to purchase United States currency on the "black market."

Unfortunately for the DC Plan, the questionable business operations of the Jamaican Plan were not learned of before the investment of the $5 million surplus note. Interviews with current and former BCJ employees and Board members reveal that GHMSI, after its initial involvement, was kept well appraised of the financial condition of the Jamaican Plan. What is less clear is how much GHMSI knew about the activities characterized by the findings in the audit.

This audit was requested by Dr. Lowe prior to his becoming CEO of the Jamaican Plan. He in fact stated he would not accept the position until an audit was completed, as he wished everything to come out and felt a number of things were not right with the accounting procedures. Lowe stated had he known how bad things were prior to the full audit, he would not have accepted the position. Since he was on the Board a relatively short time before becoming CEO, the Staff questions how GHMSI could not have seen similar indications or if they did, why no action was taken earlier.

Despite GHMSI's full knowledge of the numerous internal control problems pointed out in Peat Marwick's management letters since 1986, they failed to ensure these serious problems were corrected. These management letters will be made part of the Subcommittee's hearing record to show the extent and time frame of the problems which existed from at least 1986 and in a number of cases persists to the present. During an interview with McIntosh, he said the issues in the management letter were "trivial." However, these same findings were serious enough to eventually warrant both Peat Marwick and Price Waterhouse to qualify the year-end financial statements for BCJ for 1990 and 1991.

Many of the findings in the internal audit were verified during Staff interviews of current and former BCJ employees. Each confirmed in varying degrees the use of special benefits to compensate senior management during the late 1980s to avoid the high rate of taxation. One senior management member described how a travel account was used to compensate senior management and avoid taxes. These executives would be authorized a sum of money for overseas travel. Legitimate travel was paid from this; but the remainder, and perhaps the majority, depending on the executives, was paid to the person anyway, even if there was no travel. This was accomplished by the executive obtaining false travel vouchers from a "friend" in a travel company and submitting these as "proof" of travel. When asked if this was legal, the executive said no, the Jamaican Government would require taxes be paid on this money.

One BCJ employee confirmed the black marketing activities in an interview with the Staff. He said he obtained Jamaican dollars for senior management numerous times for the company to in turn purchase U.S. dollars on the black market. This was necessary because of the lack of foreign currency in Jamaica at the time and the length of time required to legally obtain it. He, himself, once made a black market currency purchase for the company. This person alleged he advised Peat Marwick of these practices during their audits, but they referred the matter to McIntosh who "handled it." He heard nothing further about this. However, the problems did not appear in subsequent management letters prepared by the accountants.

A more serious conflict of interest involving the former President of the Plan, Mr. McIntosh, was uncovered by the Staff during recent interviews in Jamaica. It was determined that McIntosh was on the Board of Directors (through 1992) of Computer Programming and Services (CSP), a firm which still provides computer services to the Jamaican Plan. The expenses charged by CSP have risen to the point where both the Superintendent of Insurance and Price Waterhouse have expressed concern since 1990 over the amount and how this is adversely affecting their overhead rate. The category of computer and data processing expenses annotated in the BCJ insurance returns under the 28th schedule, entitled "Expense of Management," rose from a low of 10.2 percent of total management expenses in 1987, to 20.4 percent in 1990 and 21 percent in 1991. McIntosh recently told the Staff the BCJ Board (prior to affiliation) approved his participation on the Board of CSP and that of Cedar Construction, which had the contract for the Plan's new headquarters complex. Although it is not clear how soon GHMSI became aware of this conflict, it might have been as early as 1989.

The Staff learned that the Board of BCJ, which included Messrs. Gamble and Giuliani of GHMSI, had considered potential legal action against the individuals involved in these schemes, particularly the former Vice President of Finance but chose not to do so. The reason provided by Dr. Lowe, the current CEO of BCJ, was that they feared the negative publicity the scandal might cause, and not enough work was done to substantiate the fraudulent activities.

Another situation that could have been avoided by GHMSI if it had performed an adequate due diligence study concerns Jamaican currency regulations. It does not appear that either Mr. Gamble or the GHMSI Board knew that at the time of the initial investment, the Government of Jamaica did not permit the repatriation of U.S. currency, which would have included the DC Plan's investment and any future profits or earnings. Thus, the DC Plan, unknowingly, had essentially locked itself into a financial investment in Jamaica that it could not get out of, nor profit from. By the time the law changed, unfortunately, due to inflation and poor finances, there were no profits or earnings to repatriate.

In his interview with the Subcommittee Staff, Mr. Gamble joked about some of the impractical schemes he and other DC Plan officers considered to repatriate their investment. In a modern-day version of the 18th century rum trade, they considered for a time using their greatly devalued Jamaican dollars to build sailing boats in Jamaica to bring to Miami to sell for U.S. currency. Humorous or not, this discussion serves to exemplify the DC Plan's officers' lack of management sophistication, especially in regards to international business.

The Staff has learned that the DC Plan's investment in Jamaica has increased to $6,500,000, due to additional accounts payables to the DC Plan. In 1990, the Superintendent of Insurance informed BCJ that they needed a $2 million Jamaican infusion, as they did not meet reserve requirements; and GHMSI provided $152,000 in cash and $848,000 in book entries to ease Jamaica's accounts payable to GHMSI.

The Staff has learned that the Virginia Insurance Department has refused to accept as an asset the $6,500,000 investment of the DC Plan in Jamaica. It appears that their decision was predicated on a number of factors, including: The fact that the Plan misrepresented the existence of a surplus note; no provision for repayment of the investment, except in the event of default; the 1990 and 1991 outside accountants' qualified opinions of BCJ, due to a breakdown in internal controls; the 58 findings identified by the internal audit performed in September, 1990, which also identified a serious problem of a lack of internal controls; and since there is no actual note to support the "loan," the impossibility for the Plan to obtain a valuation from the National Association of Insurance Commissioners (NAIC) as required by Virginia regulation.

In sum, the Staff found that GHMSI's involvement in the tangled web of Jamaica may result in a potential loss of $6,500,000 in subscribers' funds.

B. *CapitalCare*

CapitalCare is an Individual Practice Association Health Maintenance Organization (HMO) that provides managed care benefits to approximately 100,000 people in the Washington, D.C., Metropolitan area. It can be offered as a sole carrier or as an alternative carrier to clients who want to provide HMO benefits on a fully insured or self-insured basis. CapitalCare also provides in-network management for both point-of-service and point-of-sale programs. It is a stock, for-profit corporation, and all of the outstanding shares are owned by Group Hospitalization and Medical Services, Inc. CapitalCare, although now profitable, operates in a deficit position and like most of GHMSI's other subsidiaries, is financially dependent on its parent.

The Corporation was incorporated in the District of Columbia on June 22, 1984, and is licensed to operate in Virginia and Maryland. All of the outstanding shares are owned by Group Hospitalization and Medical Services, Inc.

According to past and present employees interviewed by the Staff, CapitalCare was formed because GHMSI knew it was getting "eaten alive" by other health plans that were already running HMOs. GHMSI decided that it needed to compete with other area HMOs, and, according to David Metz, the former President of CapitalCare, Joe Gamble "dragged GHMSI into action." One former employee said that GHMSI was so insistent on protecting its market that it may not have known all the ins and outs of managed care before jumping in, but did so anyway.

In 1984, Gamble brought in a management team with experience in the HMO business, some coming from the George Washington University HMO, including David Metz, CapitalCare's first President.

CapitalCare, the Staff found, suffered many of its earliest and lingering financial and management problems due to its initial start-up. CapitalCare was formed as a free-standing corporation rather than a line of business within BCBSNCA, a business decision that had been made by Gamble prior to his hiring of the CapitalCare management team. According to David Metz, he remembers the HMO's initial capitalization only to be approximately $400,000, an amount that he said really wasn't sufficient for an undertaking of CapitalCare's size. CapitalCare was debt financed, so it started operations in a deficit position.

The timing of GHMSI's decision to enter managed care has also been an issue of criticism by current and former GHMSI officials. It was stated more than once to Staff investigators that CapitalCare had to "play catch-up" in the HMO scene. At the time CapitalCare was created, several other respected HMOs, such as Kaiser and the George Washington University Health Plan, were well under way. These Plans had already established themselves and taken many of the healthier participants who would be interested in HMOs. Thus, CapitalCare was forced to accept less healthy individuals and/or offer lower rates than its competitors to break into the highly competitive HMO market. GHMSI chose to do both, according to Metz, who knew that it would pay for these decisions for some time to come. Metz stated that with this in mind, CapitalCare's strategic plan did not even include a profit for the HMO for at least 5 years.

Metz said that he did not want CapitalCare to get into the Federal Employees Health Benefits Program (FEHBP) because it was, as he termed it, "a loser." Despite his concerns, Metz said, Gamble decided to have CapitalCare participate in the FEHBP in 1986.

Several BCBSNCA officials have told the Staff that CapitalCare needed to get into the FEHBP as a major source of enrollment and to establish credibility as an HMO. Working under this mode, CapitalCare scrambled to contract with as many doctors, hospitals, and subscribers that it could. According to Tappan Wilder, former Director of Communications and Corporate Planning for CapitalCare, in reaching out for this large enrollment the HMO got away from the tight model that it once was.

John Kahl, BCBSNCA Vice President and General Manager of Major Accounts, told the Subcommittee Staff that CapitalCare suffered from poor pricing practices from the beginning. It set its rates low to attract customers but eventually had to raise them to meet financial obligations. This cycle of events only drove subscribers away, decreasing revenues while costs were increasing. This occurred in 1988, when CapitalCare took a $10.2 million loss that Metz attributed to "heavy [claims] hits" in the FEHBP. Metz stated that he didn't consider this hit so bad, considering that he had been expecting a $17 million to $40 million loss. A chart indicating the enrollment numbers from 1985 to 1991 is below. The total year-end numbers reflect the number of subscribers without their dependents:

1985	1986	1987	1988	1989	1990	1991
526	11,110	39,058	59,872	53,334	39,057	39,531

CapitalCare experienced a series of significant problems in the short period that it participated in the FEHBP, which included some monetary penalties and embarrassing revelations about the HMO's lack of administrative and internal controls.

In 1991, the Office of Personnel (OPM), which oversees the FEHBP, claimed that CapitalCare owed the Government retroactive premium rate adjustments for 1988 through 1990. For each of these years, OPM felt that it was overcharged $850,000; $5 million; and $268,000, respectively. These rates charged to Federal workers were above and beyond what the civilian community was paying for the same product (coverage) during that period. Smith said that OPM had been very open to the idea of working with CapitalCare as an HMO, and had really made only one request: That Federal employees pay rates equal to those being paid by others in the community.

OPM was very concerned that CapitalCare could not produce the documentation to support its rate charges to other groups in the community. OPM felt this indicated a serious lack of administrative and internal controls, which the Staff feels was a standard in the earliest years of the company. A settlement was reached, resulting in the Government's recouping more than $1.8 million from CapitalCare. This was achieved by OPM withholding approximately $1.2 million in premiums and collecting approximately $700,000 directly from the HMO.

OPM said that it made "sure" CapitalCare was a financially sound business, but that it never did any serious monitoring of it. Representatives from OPM told the Staff that OPM relies on State regulators to raise red flags for them, and none had been raised regarding this particular HMO. Also, Smith said that CapitalCare was backed by GHMSI, and was maintaining its customer service, so there was no need to panic to the point of removing the HMO from the FEHBP. Smith said that the relationship between the Government and CapitalCare improved with the arrival of Peter Kongstvedt, M.D., as CEO of the HMO in June, 1990.

Effective January 1, 1992, CapitalCare withdrew from the FEHBP program because of its inability to secure the approval from OPM for some proposed benefit changes which may have exposed the HMO to further financial losses it would not be able to control.

CapitalCare, for many of the reasons explained above, was from the outset a financial loser for BCBSNCA, until its turnaround in 1990. At year end 1990, CapitalCare reported an accumulated deficit of almost $20 million, after experiencing losses through 1989. Since then, the HMO has been profitable and hopes to remain a viable entity. The following chart depicts the historical losses and gains for the HMO:

CapitalCare (Losses) and Gains

(In millions)

1985	1986	1987	1988	1989	1990	1991	Projected 1992
($2.4)	($3.7)	($4.3)	($10.2)	($.9)	$1.7	$.097	$4.5

As mentioned before, Metz stated that CapitalCare's lack of funding contributed to the HMO's losses. He said that CapitalCare generated its own money to pay its claims and that no money was infused from BCBSNCA, causing debts to grow. Some of these debts were not paid because they were subordinated and could not be repaid without the permission of the Virginia and Maryland Insurance Commissions. The history of these loans is outlined below:

* According to Price Waterhouse, in 1985 CapitalCare entered into an agreement with a local bank whereby the bank agreed to lend the HMO up to $3 million. In 1986, the borrowing authority was increased to $9 million. As of December of 1986 and 1985, outstanding loans from the bank totalled $6 million and $2.9 million, respectively.
* As of December, 1986, and 1987, outstanding loans from the bank totalled $6.9 million and $10.8 million, respectively.
* As of December, 1988, and 1989, outstanding loans from the bank totalled $14 million. As of December, 1988, and 1989, outstanding loans from BCBSNCA totalled $8.3 million and $9.3 million, respectively.
* As of December, 1990, and 1991, amounts outstanding under the $14 million line of credit totaled $14 million. Interest on this was paid monthly and totaled $1.4 million and $1.5 million for these years. For this same time frame, outstanding loans from BCBSNCA totalled $9.3 million.

* According to Dr. Kongstvedt, as of January, 1993, CapitalCare still has these two outstanding debts, though he could not, at the time, remember the total amounts involved.

Since 1990, the first year that the HMO saw year-end profits, CapitalCare has had a significant turnaround in terms of its financials. Although there was a significant slide in net income the following year, there are several reasons given for the successes that the HMO hopes have come to stay.

First and most-often quoted as the reason for CapitalCare's improvements was the 1990 removal of David Metz as President of CapitalCare and the hiring of Dr. Peter Kongstvedt as the HMO's new administrator. Kongstvedt was brought to the HMO by Ben Giuliani, after he had established something of a national reputation for himself by "saving" several troubled HMOs throughout the country. Kongstvedt told the Staff that when he arrived at the HMO, it immediately became apparent that basic management practices had not been installed at the HMO and that the management team which remained could not answer even the most basic questions regarding major accounts, such as the FEHBP. In Kongstvedt's words, "They didn't last long. They really just didn't know how to run an HMO. It was lacking a lot of the basics."

C. *EMTRUST*

The Staff found that EMTRUST, a joint venture between BCBSNCA and the Fairfax Hospital holding company, was ill conceived, apparently mismanaged, and financially troubled from its inception. Created to serve the needs of small to medium-sized, self-insured employers in the Metropolitan Washington area, EMTRUST assumed a fiduciary duty to their clients—a duty that the Staff believes EMTRUST possibly violated.

EMTRUST was incorporated on April 23, 1987, in the District of Columbia, as a for-profit corporation. Its offices are located in Alexandria, Virginia. EMTRUST is a joint venture between GHMSI and INOVA Health Systems, each owning equal shares of EMTRUST's stock, and each equally liable for its debt position. INOVA is the holding company for several hospitals, including Fairfax (Virginia) Hospital. EMTRUST is one of INOVA's 40 subsidiary or partnership operations.

EMTRUST is an employee benefits management company which designs and administers health benefits programs on behalf of its clients. Like many of its sister GHMSI subsidiaries, EMTRUST operated in a deficit position from its inception and has only created additional liabilities for BCBSNCA. Its existence was at all times dependent on the financial resources of its parent corporation to cover the over $6 million that it has lost. The Staff has been informed that BCBSNCA plans to dispose of this company, writing off its debt to BCBSNCA.

As of July, 1992, EMTRUST's Board of Directors consisted of three GHMSI officers, Joseph Gamble, Ben Guiliani, and David Kestel; and three officers of INOVA Health Systems, Knox Singelton (INOVA's President), John O'Brien (INOVA's assistant treasurer), and John Sielert.

EMTRUST's Treasurer, John P. O'Brien, of INOVA, told the Staff that EMTRUST was created to market the single-employer trust program to Northern Virginia employers, steering the employees of EMTRUST's clients to the Fairfax Hospital system and its participating physicians. The clients would then be captive to INOVA's hospitals and participating doctors. INOVA hoped this arrangement would help fill its hospitals' beds and generate revenue for INOVA operations. Likewise, GHMSI hoped that the operation, particularly the claims processing and captive insurance market, would increase GHMSI's revenues.

EMTRUST's clients relied on EMTRUST to manage their trust account to receive and pay claims for their employees' health care. The clients' trust accounts are managed by an EMTRUST subsidiary, Belle Haven Service Corporation. As trustee for EMTRUST's clients, Belle Haven Service Corporation has a significant fiduciary responsibility to manage and invest the funds that the clients give to EMTRUST to pay medical claims.

Each EMTRUST client received medical aggregate stop-loss coverage as part of the contract with EMTRUST. The medical stop-loss coverage is underwritten by GHMSI. In practice, GHMSI ceded 100 percent of the risk to EMTRUST's subsidiary, EMTRUST Reinsurance Corporation (EMTRUST RE). EMTRUST RE retroceded individual claims risk to other companies, including Lloyd's of London and National Capital Reinsurance, another BCBSNCA subsidiary.

According to BCBSNCA President Ben Giuliani and EMTRUST's former President Eric Vincent, INOVA's senior management believed BCBSNCA was making money on the stop-loss portion of the EMTRUST business. As a result, EMTRUST

RE was created to allow INOVA, through EMTRUST, to share in the profits—and risk—of the insurance product.

EMTRUST RE was incorporated in January, 1988, in the District of Columbia. As a reinsurance company, it must maintain $600,000 in capital and reserves. By year-end 1990, EMTRUST RE's reserves had dipped to $493,947; and by December 31, 1991, EMTRUST RE was in serious financial trouble, reporting its reserve/surplus at ($1,269,387). EMTRUST RE lost $500,000 on underwriting in 1990, and another $2.3 million in 1991. BCBSNCA has forecasted an additional operating loss in 1992 of $2.3 million.

INOVA and GHMSI have had to make additional capital contributions to save the insolvent company. EMTRUST RE's continued losses clearly caused concern at INOVA, which had hoped to profit, not lose, on the insurance side of the business. To appease INOVA, GHMSI agreed to stop ceding EMTRUST's risk to EMTRUST RE, and began placing EMTRUST's reinsurance risk in another GHMSI subsidiary, National Capital Reinsurance (NCRe), an off-shore carrier. Thus, what was to be a joint venture, with the sharing of risks and profits, became the sole risk of BCBSNCA, thereby defeating the intended purpose of the joint venture, which was to spread the risk.

In addition, as this Subcommittee has learned in past hearings, reinsurance only offers security if the reinsurance company is sound. In the event of a reinsurance failure, the initial underwriter, in this case GHMSI, would bear 100 percent of the risk. Since EMTRUST RE always operated in a deficit position, made whole only by GHMSI and INOVA, this basic tenet of the reinsurance business was ignored, since the risk was solely spread to an insolvent reinsurer, thereby not lessening any of GHMSI's insurance liability.

EMTRUST's former President, Eric Vincent, told the Staff that EMTRUST was merely a "super sales organization," which sold the products offered by other GHMSI and INOVA subsidiaries, in package form, to medium-sized employers. EMTRUST subcontracted almost all of its functions to its sister subsidiaries. For example, EMTRUST's clients' claims were processed by GHMSI subsidiary National Capital Administrative Services (NCAS); client patients received care at INOVA's hospitals through participating doctors; INOVA subsidiary, Health Cost Consultants, provided the utilization review and second surgical opinion for inpatients; GHMSI provided the stop-loss insurance; GHMSI subsidiary National Capital Insurance Agency (NCIA) collected the commissions on insurance sales; GHMSI subsidiary CapitalCare was contracted with for health maintenance organization (HMO) service, and with INOVA's Internet for participating providers; EMTRUST RE contracted with International Consulting Services, Incorporated, a wholly owned GHMSI subsidiary, to perform actuarial services on the insurance risk that EMTRUST RE assumed.

Despite the fact that EMTRUST "fronted" for its sister INOVA and GHMSI subsidiaries, Vincent told the Staff that he had a difficult time in negotiating with the other companies for a discount price. Each subsidiary was under pressure to turn a profit independently, and Vincent's peers knew Vincent was prohibited from shopping for better deals outside the GHMSI or INOVA enterprises. This left EMTRUST with little or no bargaining power and drove up EMTRUST's costs, endangered EMTRUST's market share and further reduce the possibility that EMTRUST could be profitable.

Vincent said he had a difficult time negotiating with Fairfax Hospital, HCC, and NCAS, and later learned that despite INOVA's ownership of EMTRUST, Fairfax Hospital gave better discounts to GHMSI directly than it gave to EMTRUST. Regarding NCAS, Vincent said that EMTRUST could have performed the claims processing function in-house at a much lower cost than NCAS charged, but he was prohibited from doing that, as well.

The Staff believes that the constraints that were placed on EMTRUST by its ultimate owners, GHMSI and INOVA, resulted in EMTRUST's clients paying a higher price for products that EMTRUST would have been able to achieve if it had contracted for the work outside the parents' corporations. This raises in the Staff's mind a question—Whether EMTRUST and GHMSI thereby violated their fiduciary responsibility to their clients to oversee and expend their clients' assets only in the best interest of these clients?

The Staff believes that EMTRUST may also have violated its strict fiduciary responsibility to its clients in another way. It appears that EMTRUST knowingly commingled its clients' trust accounts and paid the claims of deficient clients by using the positive balances of other client accounts.

A review of the records of EMTRUST indicates that EMTRUST pooled the majority of its clients' trust accounts in a common account and paid all claims from the central pool. In 1991, EMTRUST's external auditors warned EMTRUST that 43 of

95 client accounts were in a deficit position, totaling $3.25 million. Instead of holding claims payments for those clients who were behind in funding the trust, EMTRUST paid the claims of delinquent clients with the money that other clients had provided. By August 31, 1991, INOVA's internal auditors discovered that 56 of 132 trust balances were negative. totaling $3.85 million. EMTRUST's current management told the Staff that this practice has been halted.

It also appears that EMTRUST's management had not been reconciling its accounts since basic internal controls were lacking. It appears that EMTRUST was not reconciling both its corporate and trust accounts on a regular basis. The Staff has been assured that at no time did EMTRUST use the clients' accounts to cover operating expenses, but it did use EMTRUST RE's funds to advance funds to EMTRUST.

These were not the only examples of poor internal controls and sloppy accounting practices that the Staff found in its review. The Staff also discovered that in 1989, the D.C. Insurance Department found that EMTRUST RE commingled its funds with those of its parent, EMTRUST. This was done on a daily basis, wherein EMTRUST RE's account was swept into EMTRUST's investment account. When caught doing this, EMTRUST RE agreed to discontinue the practice.

The Staff also determined that EMTRUST's business practices were so poor that it would unwittingly pay the claims for clients that had inadequate funds to cover these health expenses. By the time EMTRUST became aware of this situation, many of the clients were so far in arrears that they merely walked away from their liability by terminating their contracts. In a number of cases, EMTRUST experienced difficulty collecting from these delinquent clients, resulting in EMTRUST's absorbing the losses. The Staff learned that EMTRUST had a policy to pay the claims on accounts even if they knew they were not adequately funded, because EMTRUST was afraid that if it did not provide this "service," the client would take its business elsewhere. Current management stated that EMTRUST no longer loans money to its clients.

As with a number of other subsidiaries, the Staff uncovered a number of questionable expenditures made by senior officers which were reimbursed by the subsidiary, even as it operated in red ink. The Staff discovered jewelry purchases at Tiffany's for Christmas presents for brokers; a sailing trip to "discuss reinsurance"; office Christmas parties; and multiple golf outings at Avenel, charged to the subsidiary. In addition, the Staff found that the former President regularly charged his dining to EMTRUST, even when only EMTRUST, GHMSI, or INOVA (and their subsidiaries) employees were in attendance.

EMTRUST's senior officers also attended the Plan's 1990 sales incentive trip to Portugal. Vincent told the Staff that if he had known that EMTRUST would have had to pay for these employees to attend, they would not have gone. However, Vincent indicated he saw nothing wrong with the trips, just that they were charged against EMTRUST. Rather, he felt GHMSI should have been charged for his employees' going to Portugal. To the Staff, the end result would still be the same—the subscriber picks up the tab for a questionable trip.

D. *GHMSI International Division*

As previously stated, the DC Plan's senior management and Board of Trustees decided that the Plan would be in a better financial condition if it could increase its revenue from outside its traditional marketing territory. Senior management convinced itself that the Plan should expand overseas, insuring the citizens of foreign countries. Through several platforms, the DC Plan transformed itself into an international insurance conglomerate. Unfortunately, it did so in a state of apparent blissful ignorance of the ultimate financial cost to the Plan and its subsidiaries.

It is, therefore, not difficult to understand why GHMSI lost money on these ventures. The exact amount lost to GHMSI by this venture is hard to calculate since, amazingly, the International Division did not keep the most rudimentary records until 5½ years after it started. The Staff's best estimate is that this Division lost over $10 million, including $2 million in 1991, and $6.7 million in 1992.

The Staff discovered that after the creation of World Access, the Plan spent its resources entering into agreements with medical providers to service World Access's clients, primarily American citizens traveling abroad. As of 1991, the Plan had negotiated agreements with over 215 hospitals in foreign countries.

Shortly thereafter, the Plan successfully bid on the medical insurance contract for the employees of the U.S. Virgin Islands, and then expanded their product, offering medical insurance to the citizens of the U.S. Virgin Islands, the British Virgin Islands, the Cayman Islands, Turks and Caicos, and Barbados. These citizens were sold Blue Cross and Blue Shield coverage, very similar to the coverage BCBSNCA offered to the citizens of the Washington Metropolitan area.

The Plan viewed these transactions as critical to their need to obtain revenue from outside the D.C. area. Unfortunately, the Caribbean expansion cost much more than it brought into the Plan.

Steven Howard, the International Division's Chief Financial Officer, told the Staff that the Plan lost money on the Virgin Islands contract because the rates were very low, the benefits were too high, and the Plan sold the product in an environment where "there isn't a lot of competition . . . [and] these people got dental care for the first time in their lives." He characterized the Virgin Islands Government employee account as "an absolute nightmare," which suffered from poor recordkeeping and poor actuarial estimates for the reserves. The actuarial work, the Staff notes, was performed by BCBSNCA staff.

GHMSI Vice President Richard Groppe told the Staff that the U.S. Virgin Islands Government had insisted on BCBSNCA opening an office on the island if the Plan wanted the contract. This stipulation came after the Plan had bid on the contract. The Plan agreed to open an operations center on the island without charging the Virgin Islands Government more than the Plan had originally bid, adding dramatically to the administrative costs of the contract.

A former employee of the Plan told the Staff that he knew that other major insurance carriers had historically lost money on the Virgin Islands Government contract, and advised Mr. Gamble not to take the contract. Years later, the former employee said, Mr. Gamble admitted that he should have listened to the former employee.

From the beginning, the Plan pushed for market penetration, undercutting the competition's prices. The Chief Financial Officer, Steven Howard, said, wryly, that "market penetration worked, but there was no real underwriting on the business until 1990 or 1991." Characteristically, the Plan had started writing the Virgin Islands account 5 years before, in January, 1985.

After entering the Caribbean market, the Plan decided to offer medical coverage to citizens of foreign countries when they traveled from their own country. To do this, the Plan, which was not licensed in foreign countries, decided to enter into joint ventures with foreign insurance carriers.

Unbeknownst to its Washington area clients, GHMSI became heavily involved in international operations in the mid-1980s; a practice that continued until last month. Simultaneously, GHMSI became more involved in reinsuring other foreign insurance companies than it was in ceding that risk away from itself. The danger here is immense because GHMSI relied solely on the expertise and due diligence of dozens of foreign insurance companies throughout the world to write the business and pass the majority of the risk to GHMSI. In essence, GHMSI gave the "power of the pen," that is, the ability to commit the financial resources of the DC Plan, to foreign insurance companies over which it exercised no direct control.

Astounding as it may seem, GHMSI also never audited any of the foreign insurance companies to determine if the Plan received the appropriate premium due, nor did it verify if the foreign carriers actually paid the claims as they had reported to the Plan. GHMSI relied on these unaffiliated foreign companies to process the applications and forward the premium due to GHMSI. When these companies paid claims on this business, the companies deducted the claim from premium due to GHMSI.

Additionally, the Plan created several foreign subsidiaries to service the business being written abroad. The administrative expenses (office space, employees, etc.) required additional capital from the Plan.

Mr. Groppe told the Staff that an additional drain on the International Division's assets was comprised of the overhead charge from GHMSI. Groppe said that he could never accurately budget for these charges, but would have to pay whatever GHMSI billed his division. He felt it was unfair, for example, that the International Division had to pay for GHMSI's marketing department, because his Division never used those GHMSI services.

In addition, he said his Division was stung when it received a "$2 million bill" from its parent, GHMSI, for the legal fees the Plan paid to defend itself against the 1989 lawsuit from the Blue Cross and Blue Shield Association for trademark infringement reasons. GHMSI told the Staff that the corporation spent over $1.7 million to defend against that lawsuit.

In 1985, the Plan started its effort to secretly register the Blue Cross and Blue Shield trademarks in foreign countries. The National Association discovered this in 1987, and made numerous attempts to have the Plan cease its efforts. The Plan ignored the Association's demands and continued to register the trademarks abroad. In fact, some of the Plan's overseas joint venture partners believed they were dealing with a U.S. national insurance carrier, and did not realize they were dealing

with a private company which was licensed to use the trademarks. In 1989, the Association sued BCBSNCA in Federal court in Alexandria, Virginia, for trademark infringement.

Our investigation also disclosed that GHMSI assumed insurance risk from insurance companies around the globe, and did so without the benefit of a qualified reinsurance manager. GHMSI employees accepted insurance risk on a wholesale basis from foreign carriers without:

—knowing the specific risks they were assuming (e.g., they had no control over who their partners sold the product to);

—knowing the ecomonic conditions in the countries in which they assumed the risk (e.g., they had no control over currency fluctuations that occurred after the rates were set and the product was sold);

—knowing how to price the products they were selling (e.g., there was no product in competition with which they could compare);

—knowing at what level to properly reserve for the potential losses the company would incur on the product they sold;

—consulting GHMSI's financial advisers, internal or external. (The Chief Financial Officer for the International Division told the Staff that he learned of reinsurance transactions that his superiors entered into after the fact.)

The Chief Financial Officer for the Plan's International Division told the Staff that even the most basic element of the joint ventures with foreign insurance carriers—the tracking of premiums received and paid claims—"was not standardized or well thought out from the beginning." That critical element haunts the company and regulators today, as no one has been able to track these lines of business individually or in the aggregate. Making matters worse, some of the reinsurance is "long-tail" business, meaning that even if all of the treaties could be and were canceled today, claims could continue to be made against the Plan for at least the next 2 years.

The DC Plan's reinsurance program confuses all who have attempted to determine even a rough proximation of the liabilities assumed by the company. The Staff has been told that neither the State regulators nor even the Plan to this date understand what happened, what is actually covered, and what is the actual liability of the Plan.

In addition, GHMSI wrote business and ceded the risk to its wholly owned companies. The Staff fails to understand how these transactions spread any risk whatsoever. In a transaction reminiscent of the Subcommittee's 1991 investigation of fraud and abuse in the offshore reinsurance industry, the Staff found a totally inexplicable arrangement wherein "International Health Benefits of Ireland and/or their subsidiary and/or associate and/or affiliated companies" ceded risk to GHMSI. Joseph Gamble signed the treaty on August 16, 1990, retroactive to January 1, 1990. A separate treaty, containing precisely the same wording and dates, ceded the same risk from "Group Hospitalization and Medical Services, Inc., and/or their subsidiary and/or associate and/or affiliated companies" to International Health Benefits of Ireland. This treaty appears to accomplish nothing but to allow the DC Plan to cede and retrocede risk to itself.

The very nature of some of the foreign joint ventures would be amusing, were it not for the fact that all of the assumed risks are borne by the unwitting BCBSNCA subscribers. For example:

—In 1989, GHMSI accepted 100 percent of the risk that the PZU Insurance Company of Warsaw, Poland, wrote for medical/surgical coverage for PZU clients when they traveled outside the Communist Bloc.

—In 1991, GHMSI accepted 50 percent of the risk that CESKA STATNI POJISTOVNA, a Czechoslovakian insurance company, wrote for emergency medical and accidental injury for CESKA clients when they traveled outside of Czechoslovakia.

—In 1991, GHMSI accepted 50 percent of the risk that INGOSSTRAKH Insurance Company of Moscow, USSR, wrote for medical/surgical accidental injury or medical emergency for INGOSSTRAKH clients when they traveled outside the USSR. This coverage also included the repatriation of the client's remains should the client expire while abroad. If a person with INGOSSTRAKH coverage traveled from Moscow to Paris—or anywhere else—that person could buy $25,000 coverage for $15, for a seven-day trip. GHMSI would receive $6 for assuming 50 percent of that risk.

The Subcommittee Staff has been informed that a significant amount of fraudulent claims have been sustained by other insurance carriers who have written or assumed risk on health insurance coverage for some citizens of the former Communist Bloc. Other companies have discovered that some citizens of those countries have purchased such travel insurance to obtain quality medical treatment in other countries. The Staff is concerned, therefore, that the Plan and its subsidiaries have never audited the claims files of their foreign joint venture partners to determine the amount of fraudulent claims they have possibly paid.

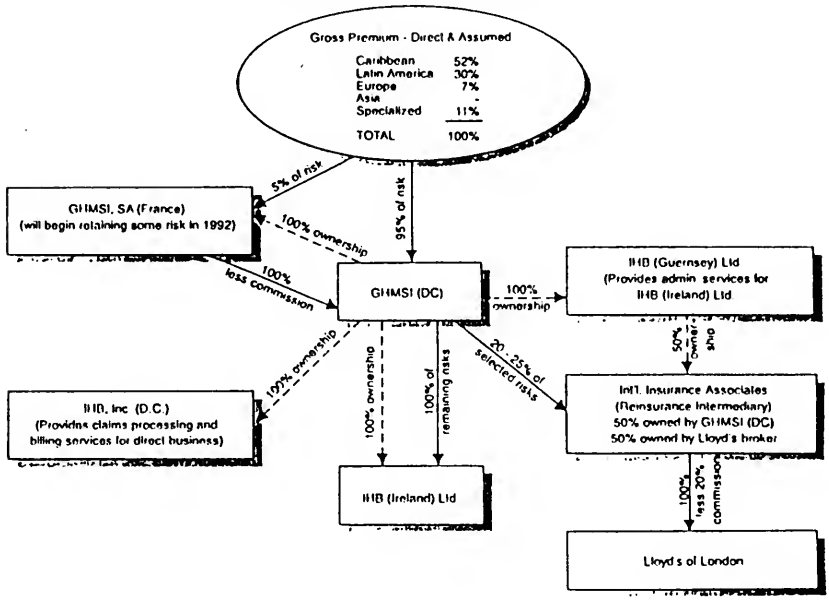
In addition to the above, the International Division also committed GHMSI's Washington Metropolitan area subscribers to the possible risks of insurance policies written by the following companies, none of which the Staff would consider household names in the United States:

—Seguros St. Paul de Venezuela
—Western Provident Association, UK
—Seguros Bancomercio SA, Dominican Republic
—La Universal de Seguros Reaseguradoro, Santa Domingo
—Blue Cross of Jamaica
—Association International de Prevoyance Societe
—Group de Assurances Nacionales, Paris
—Seguros La Provincial
—Seguros la Commercial, Mexico
—Seguros Granai and Towson of Guatemala
—Insurance Corporation of Singapore
—Serguros E Inversiones, San Salvador
—PT Asuransi Central Asia, Jakarta, Indonesia
—Hong Leong Assurance, Kuala Lumpur, Malaysia
—La Positiva Compania Regional de Seguros, Peru
—Tugu Mandiri, Indonesia
—Metropolitano de Seguros de Vida, Panama

Steven Howard, the Chief Financial Officer for the International Division, complained to the Staff that the people making the business decisions failed to seek the advice of the Financial Section. He said that instead of starting one program slowly, carefully, and methodically to determine if the overseas insurance sales would work, the Plan's officers, primarily Groppe and Gamble, sought out and initiated foreign ventures faster than the support staff could track them.

As an example of the confusion caused by this, the Staff cites the following chart which, according to the Chief Financial Officer, traces the premium income flow of the International Division:

GHMSI International Division
Summary of Flow of Transactions for 1991



E. *GHMSI Insurance Division*

While the Plan's International Division expanded around the globe in search of foreign partners, the Plan's Insurance Division, headed by David Kestel, also created foreign reinsurance companies, including one in Dublin, Ireland. Kestel told the Staff that he did not want his Division's reinsurance mixed with Groppe's business. GHMSI projects a $7 million loss for the Insurance Division for 1992.

Formed to write insurance risk in the United States, the companies that made up the Insurance Division ceded risk to a different set of wholly owned foreign-based companies. While GHMSI wrote stop-loss insurance for its subsidiary clients (primarily NCAS, EMTRUST, and Protocol), it did not want to book that risk with the Blue Cross and Blue Shield core business. So GHMSI created National Capital Reinsurance Company, Incorporated, on Barbados. As GHMSI wrote insurance, it ceded to NCRe.

Later, not to be outdone by the International Division, the Insurance Division opened National Capital Reinsurance Limited, in Dublin. NCRe-Ireland was then used as the Insurance Division's platform to cede risk to Lloyd's of London. And, in perhaps the most bizarre transactions, the Staff discovered GHMSI accepted risk from Lloyd's of London.

While the *International* Division went to the time and expense of creating a joint venture subsidiary with a Lloyd's broker on the Isle of Guernsey (International Insurance Associates) to cede risk to Lloyd's, the *Insurance* Division was engaged in its own transactions with Lloyd's through a separate broker. Shockingly, the Chief Financial Officer of the International Division knew nothing about the Insurance Division's forays with Lloyd's until the Subcommittee Staff told him last month. It was the Insurance Division that both ceded and assumed risk from Lloyd's. Likewise, the Chief Financial Officer for the Plan's Insurance Division knew nothing of the International Division's relationship with Lloyd's until the Subcommittee told him. Steven Howard, Chief Financial Officer for the International Division, called this situation "bizarre."

David Kestel, who until very recently ran the Insurance Division, told the Staff that NCRe-Ireland "began accepting risk from Lloyd's syndicates" in 1990, because the syndicates and a broker told him the line was profitable and assured him verbally that Lloyd's was not retroceding NCRe's risk back to NCRe. While the Lloyd's-to-NCRe reinsurance contracts do not reflect the risk that is ceded to the Plan's subsidiary, Kestel informed us that the risk was made up of stop-loss coverage U.S. carriers had written and ceded to Lloyd's. Kestel did not know the identity of the carriers, the specific underwritten risk, or anything else about the business. Kestel said that he thought the business had been profitable for NCRe, but was not sure. The Insurance Division's Chief Financial Officer also did not know if the business had been profitable or a loss. Since NCRe is being closed by the Plan, the risk will revert to the Plan directly.

The Insurance Division also accepted risk from the following companies:

—BCS Life Insurance Company, Chicago
—Advanced Marine Enterprises
—Ranger Insurance Company, Texas
—North American Life and Casualty
—Security Life Insurance Company, Minnesota

One of the most dangerous and risky transactions in the insurance industry involves reinsurance . . . the practice of spreading the insurance risk between and among several insurance companies. As this Subcommittee has determined through previous hearings, several insurance companies have relied upon reinsurance, only to find the transactions to be a meaningless, yet costly, exercise. In fact, many insurance companies have failed because of their reinsurance transactions alone.

GHMSI and its subsidiaries did reinsure with other carriers. The Plan has been unable to determine if it has paid out more in premium than it has collected in claims against their reinsurers. Thus, the potential for future losses is unknown.

F. *Health Management Strategies International*

Health Management Strategies International, Inc., was incorporated in the District of Columbia on January 10, 1985, and is a second-tier subsidiary of GHMSI. It is 100 percent owned by GHMSI Companies, Inc., itself, a wholly owned subsidiary of the GHMSI. It employs 370 people and is one of the nation's largest mental health managed care companies. It delivers a full range of mental health and medical/surgical management programs, offering its services to over 800 clients who, in turn, represent over 11 million members throughout the United States. The services are administered by a professional staff of nearly 300 licensed professionals with extensive clinical experience.

Its programs include utilization management reviews and a Mental Health Provider network, which provides access to an integrated panel of multidisciplinary providers, including psychiatrists, psychologists, registered nurse clinicians, hospitals, and alternative treatment programs.

The Staff found that Health Management Strategies International (HMSI) was one of the few subsidiaries that made a profit. The majority of its business was related to a contract with the Civilian Health and Medical Plans United States, commonly called CHAMPUS, which constituted 62 percent of their total revenue for 1991.

Although a profitable subsidiary, recent divestiture attempts and employment agreements at HMSI have raised some concerns. The former Chairman of the Board of the Plan, Charles Duvall, told the Subcommittee Staff that he was exceptionally upset when in late July, 1992, the then-President, Joe Gamble, got him and the other members of the Board to approve a separation agreement for E. Seton Shields, the President, and three of her Vice Presidents. Mr. Duvall told the Staff that he felt that they had been "railroaded" into signing off on this lucrative "Golden Parachute" separation package, which totaled more than $1 million.

The contract assured Ms. Shields $400,000 when HMSI was sold and a 3-year salary guarantee of $160,000 per year, plus incentive compensation (bonus) of no less than $45,000 per year, even if Ms. Shields does not work. The three senior Vice Presidents of HMSI would receive bonuses of $200,000; $100,000; and $100,000, respectively. The total sales bonuses came to $800,000, plus a minimum of $615,000 in guaranteed salary for Ms. Shields if she chooses to activate it.

Thus, it would appear that Ms. Shields could obtain up to $1,015,000 from the Plan, if and when HMSI is sold. When questioned about such a large amount at the August 3, 1992, Board of Trustees meeting, Mr. Giuliani, the new President of GHMSI, responded that he supported it and that "the arrangement is within the range of usual bonuses which are paid under similar circumstances."

The Staff feels that such generosity to four senior officers is inappropriate at a time that GHMSI is publicly claiming that it has embarked upon an emergency program to save costs to stave off bankruptcy. It should be noted that just after the Christmas holidays, the Plan's Chief Executive, Benjamin W. Giuliani, publicly announced a massive cost-cutting effort to put the giant health insurer back on its financial feet. He stated that:

> This is a painful process, but we must reduce our administrative costs in order to meet our customers' needs in an extremely competitive—and price-sensitive—marketplace.

Even though HMSI was a financially successful company, at this time, with the Plan announcing it must lay off over 300 employees, the Staff questions the propriety of a $1 million "Golden Parachute" to Ms. Shields and $400,000 to her top three officers. The Staff is also concerned by Mr. Giuliani's August statement to the Board that such an arrangement is within "the usual bonuses" paid. It raises the question that other Plan executives may have received lucrative bonuses like this one that the Staff has, to date, not uncovered.

G. *National Capital Administrative Services*

Incorporated in the District of Columbia on November 3, 1983, as a wholly owned, for-profit subsidiary of GHMSI, National Capital Administrative Services (NCAS) is a Third Party Administrator (TPA) of medical insurance claims. NCAS has one wholly owned subsidiary, NCAS Insurance Agency (NCAS/IA). NCAS/IA was incorporated in 1987 to enable NCAS to receive reinsurance commissions and fees which it cannot, as a TPA, otherwise collect. NCAS/IA is a paper entity, with no employees or tangible assets.

Since its establishment, NCAS has been operated by two key managers, William Hendren and Joseph Crowley. Mr. Hendren is President and CEO of NCAS and NCAS/IA. Until late in 1992, when he was terminated without explanation at the direction of Benjamin Giuliani, Mr. Crowley was NCAS's Vice President for Corporate Operations. Mr. Crowley was also President (and remains one-third owner) of NCAS-Midwest, a Detroit, Michigan, TPA that was owned by NCAS until 1991.

The Staff found NCAS to be intertwined with GHMSI, as indicated by Mr. Hendren holding the titles of Vice President of GHMSI and President of the latter's TPA Division. In addition, NCAS and NCAS/IA officers and directors—i.e., Joseph Gamble, until his retirement), Benjamin Giuliani, Richard Cook, and William Poffenberger (until his recent termination)—are or were also officers of GHMSI.

NCAS operations are essentially organized around a claims processing computer system, which it leases from Insurdata, a Dallas, Texas, TPA with a substantial claims processing software and hardware capability. NCAS has an ownership interest in Insurdata, amounting to more than 18 percent of its outstanding stock.

NCAS uses "ports" (computer hookups) to their Fairfax, Virginia, office from Insurdata's location in Texas to process claims for their accounts. NCAS initially obtained the rights to market Insurdata's claims processing system on a local (Mid-Atlantic) basis for $325,000, and subsequently purchased the rights to sublicense the system nationwide for $2.4 million. NCAS has exclusive marketing and license rights for Delaware, Maryland, Virginia, West Virginia, and the District of Columbia, and restricted rights for the rest of the United States, Puerto Rico, and the U.S. Virgin Islands. NCAS may only sublicense to other Blue Cross and Blue Shield Plans, their subsidiaries, or an affiliate for TPA services.

From the Subcommittee's standpoint, perhaps the most striking finding in its examination of NCAS is the company's continuously weak and unstable financial position. For example, as shown by the table below, since its inception NCAS has consistently posted net losses.

	1985	1986	1987	1988	1989	1990	1991
New Loss (in millions)	($1.3)	($1.5)	($1.8)	($2.7)	($2.5)	($.988)	($.841)

Likewise, its cumulative deficit has grown enormously over the years, from $1.7 million in 1985 to $7.8 million in 1988, and more than $12 million by the end of 1991. GHMSI estimates at least a $500,000 loss at NCAS for 1992.

In 1986, GHMSI established a $1 million line of credit for NCAS, with interest payable at prime, plus one percentage point. This line of credit was increased to $2,000,000 in 1987; $3,000,000 in 1988; and $4,000,000 in 1990. By the end of 1991, $3.9 million of this amount had been drawn down, and, subsequently, NCAS was notified by GHMSI that until further notice they could not utilize the remaining funds. In his deposition before the Subcommittee, NCAS President Hendren confirmed that no interest payments on this line of credit have ever been made to GHMSI.

It is worth noting that while the line of credit was not in and of itself harmful, over time it came to be relied on in such a way and to such an extent that it did become an important contributing factor to NCAS's long-term financial instability. For example, former NCAS Vice-President, Joe Crowley, told the Subcommittee Staff that while he could chalk up NCAS's sustained losses between 1985 and 1988 to normal start-up considerations, he did not feel that this rationale could explain the losses thereafter. Mr. Crowley added that he believes the latter can be explained, at least in part, by the attitude reflected in the words NCAS President Hendren often expressed to him when he raised questions about company expenditures—"Don't worry, it's the Plan's money." This attitude towards GHMSI's seemingly endless deep-pocket—"rubber money," as Mr. Crowley referred to it—was well-known within NCAS, according to other former employees who spoke to the Subcommittee Staff.

The outstanding balance on the line of credit and accrued interest to date are as follows:

(In millions)*

	1986	1987	1988	1989	1990	1991
Loan Amount*	$1.0	$1.2	NFA**	$2.8	$3.2	$3.9
Accrued Interest*	$0.028	NFA**	$0.278	$0.567	$0.894	$1.2

** No figures available.

Subcommittee investigators determined that NCAS's persistent inability to become a financially sound and profitable enterprise is largely the result of widespread and deep-seated mismanagement, poor judgment, questionable business practices, and wholly inadequate oversight on the part of its GHMSI parent. This determination is based on a number of Staff findings, including:

—overly complicated, confused, and/or wholly deficient accounting systems for billing and determining actual costs of work performed;

—failure to verify the accuracy of fees remitted to NCAS by self-billing clients;

—manipulation of financial data in budget forecasts, contracts, and other documents to mask the problems with company operations and attendant losses;

—filing inaccurate, misleading and/or false claims with the Agency for International Development;

—abusing client bank accounts established for the purpose of holding funds for claims payments;

—conflicts of interest on the part of NCAS executives; and,

—sizable cash bonuses to William Hendren, the President of NCAS, in the face of major, sustained losses.

An October, 1990, BCBSNCA internal audit of NCAS found a number of significant deficiencies in the accounting area. In particular, it was found that there was no documentation to verify the accuracy of rates. Without such verification, the report states, "NCAS management cannot be assured that the rates being delivered will achieve the targeted profit." In addition, the auditors found that the NCAS accounting system did not have a mechanism to ". . . adequately identify and accurately price non-standard services . . . and overall gain/loss results. . . ." The report notes that such cost information and analysis of group gain/loss results ". . . is vital to ensuring overall profitability." The auditors also found that files containing rate information were incomplete or not available.

In a subsequent audit conducted by the Defense Contract Audit Agency (DCAA) in 1991, findings similar to those uncovered by the BCBSNCA internal audit were re-

ported. The DCAA audit found that NCAS did not have a cost accounting system in place that segregated costs by cost center or contract. This finding is significant because it indicates that NCAS had no precise way to determine the actual cost of services it was performing for a particular client and, moreover, how much to bill the latter. This became especially problematic, for example, in the situation that arose with the Agency for International Development (AID) (see below), where NCAS asked for additional reimbursement beyond the contract's fixed-price stipulations, using inaccurate and faulty data traceable, in part, to this cost accounting deficiency.

Finally, in a series of interviews with Subcommittee Staff, former NCAS accounting department employees were extremely critical of their experiences at NCAS along these lines. One of them, a former Accounting Supervisor, told Subcommittee Staff that she was never satisfied regarding the accuracy of billings to certain clients, such as the Agency for International Development, and regarded the situation she encountered in this respect as being indicative of a generalized pattern of mismanagement in accounting activities at NCAS. The other employee, the former Director of Finance and Administration, in responding to a written question from Subcommittee Staff, simply said that ". . . there were too many examples of bad accounting to detail," in her reply.

Concerning this AID contract, the Staff found that in January, 1988, NCAS and the Agency for International Development (AID) entered into a fixed-price contract, whereby NCAS agreed to provide administrative and support services for health and accident coverage for foreigners visiting the U.S. under the auspices of AID. In April, 1989, NCAS filed a claim with AID under the Federal Acquisition Regulations "disputes" clause, seeking $321,553 in additional compensation. NCAS maintained that it had incurred extra expenses owing to AID's failure to comply with the contract's provisions regarding enrollment data. After receiving additional information from NCAS purporting to show the "actual" costs incurred beyond the contract's fixed-price provisions, AID paid this claim in March, 1990. In 1990 and 1991, NCAS filed two more such claims for equitable adjustment—$194,772 and $228,043, respectively—citing problems similar to those encountered in connection with the first claim. Neither of these claims has been paid.

According to an investigation conducted by AID's Inspector General regarding the 1988 and 1989 claims, the supporting information supplied by NCAS that purported to show the actual additional hours worked was, in fact, not "actual" but, rather, estimates derived from incorrect, incomplete, and/or non-existent data. Regarding the 1988 claim, the IG concluded that the additional reimbursement requested by NCAS was based on "company losses due to underbidding," and not, as NCAS maintained, because of faulty or defective enrollment data submitted by AID. Indeed, the IG reports that in an interview, NCAS Vice President Joseph Crowley ". . . admitted that the bottom line had been preselected and that the supporting schedules were then prepared to fit the selected number." Former NCAS Accounting Department employees and IG investigators told Subcommittee Staff that the $321,553 claim amount was virtually the same sum that NCAS lost on the AID contract in 1988.

Similarly, in examining the records used to support the 1989 claim by NCAS, the former Director of Finance and Administration found that the extra labor hours and costs cited therein were *estimates* based on falsified employee timesheets, inflated labor hour and overhead rates, and fraudulent "extrapolation" techniques. In the case of the latter, for example, this same former employee determined that NCAS inflated the number of additional labor hours by purporting to develop an "average" of the hours various employees worked on AID claims each day, over a short period of time. This figure was then used to calculate figures for the full year. In determining this "average," the former Finance and Administration Director maintains that NCAS knowingly selected only those days on which employees worked on AID claims, while ignoring the many other days these employees did not work on these claims.

It should be noted that on June 6, 1991, in the presence of another NCAS employee, the former Finance and Administration Director advised NCAS President William Hendren that the claim was fraudulent and that since he had "signed a cert" (certification), regarding the information in it, ". . . he could wind up in jail." According to the former Finance and Administration Director, Mr. Hendren responded by becoming angry and telling her, in effect, that NCAS would proceed with the claim, regardless of her concerns. When she persisted in maintaining that action be taken to correct the false and inaccurate information in the claim, she was placed on leave and told that she would not be permitted to return to work unless she

agreed not to inform anyone outside of NCAS, including Government officials, of the improprieties she had found.

It is worth noting that the former employee's treatment in this regard was deeply disturbing to some NCAS employees. For example, on a form filed at the time of her departure in November, 1991, the former Accounting Supervisor said:

> If an employee attempts to right any wrong at NCAS, they no longer are welcome. That has been made abundantly clear. The way [the former Finance and Administration Director's] departure was handled was despicable and embarrassing. . . . I would just like it to be known that after I examined the AID claim and found it to be utter garbage, I realized that NCAS does not hold honesty and accuracy in high regard.

The questionable conduct on the part of NCAS in connection with these claims has been the subject of a civil suit brought by the former Finance and Administration Director and the Department of Justice, pursuant to the False Claims Act. The suit alleged that the claims were "false or fraudulent," and were "knowingly submitted" by NCAS. The suit was settled in October, 1992, and provided that NCAS pay the Government $385,000 and agree to forego its pending claims for equitable adjustment (amounting to nearly $400,000).

The Staff also determined that top-rung NCAS managers have been involved in a number of transactions that constitute a conflict of interest in terms of their positions as company executives. The most serious of these involves the 1991 sale of a financially failing arm of the NCAS network, NCAS-Midwest, to NCAS Vice President Joseph Crowley and two other NCAS-Midwest employees. The purchase was financed by a direct loan from NCAS in the amount of $250,000. Messrs. Crowley and the other new owners did not have to put up any capital, and the loan terms were unusually favorable in other ways, e.g., no interest payments for a year. While remaining an NCAS Vice President, Mr. Crowley became President of the new entity and continued to serve in these two positions until his termination in November, 1992.

This transaction becomes even more troubling when one considers two other pertinent factors:

—as suggested in a confidential memo from Mr. Crowley to Mr. Hendren written in May, 1991, the underlying purpose of the purchase was to simply get the large and continuing losses—more than $300,000 alone between June, 1988, and December, 1989—being experienced by NCAS-Midwest off NCAS's books; and,

—based on this history of sustained losses, there is little reason to expect that NCAS-Midwest's successor entity would be any more profitable. Moreover, if the new entity does not become profitable, it is reasonable to project that NCAS will be left with hundreds of thousands of dollars of additional losses; including, for example, the $250,000 loan.

The other apparent conflicts of interest involve Plan purchases from the spouses of Messrs. Hendren and Crowley. It should be noted that these transactions were reported annually on forms filed by Messrs. Hendren and Crowley pursuant to GHMSI policy. Nevertheless, these purchases were made when NCAS was operating in a deficit position and the Staff believes that their occurrence raises questions about GHMSI's oversight and management philosophy.

In Mr. Hendren's case, between 1985 and 1991, NCAS and GHMSI purchased a total of $93,600 worth of calendars, Christmas cards, and artwork from a firm in which Mrs. Hendren was a principal.

In Mr. Crowley's case, during 1990 and 1991, NCAS steered over $29,000 in business to a travel agency that employed his wife, even though GHMSI owned its own travel agency, Duncan Travel Services.

The Staff also discovered that primarily as a result of endemic cash flow problems experienced by NCAS, its client's bank accounts were routinely used in ways that appear, at best, unethical and, at worst, illegal. One way this occurred entailed a practice called "cash sweeping." As used by NCAS, cash sweeping involved the daily movement of funds, which had been deposited by a client into an account for paying medical claims, into NCAS's own operating account. NCAS, in turn, used these and additional funds that likewise had been swept out of other clients' accounts to pay claims and other operating expenses.

Aside from the highly questionable matter of failing to notify the vast majority of their clients of this practice, in some States (e.g., Michigan), cash sweeping is prohibited because it causes a client's medical claims funds to be commingled with the TPA's company funds. In addition, this practice has historically been contrary to Federal regulations applicable to Federal contracts, since it deprives the Federal

Government of any interest it might otherwise receive on funds left in its claims account for any length of time. For example, according to figures cited in the previously mentioned AID suit, it is estimated that AID was denied interest in excess of $50,000. According to this same source, other NCAS clients, such as the FDIC, Hechingers, the United Mine Workers, U.S. News and World Report, and others, also may have failed to receive interest payments owed them on their claims accounts.

Illustrative of management's attitude toward this issue, it is instructive to note that when the former Finance and Administration Director discussed the AID contract interest requirements with Messrs. Hendren and Crowley, they refused to initiate any corrective action, as shown in a transcript of a consensual recording of an exchange that took place at a meeting in October, 1991:

> *Mr. Hendren.* . . . I am not going to be proactive and go to AID and say by the way, send me a letter so I can tell you how much interest I owe you. I mean, I think it is their responsibility . . . to put some of these things in writing to us. . . .
>
> [*Former Finance and Administration Director*]: Yeah, but don't you think . . . that . . . since we are aware of it and we know about it . . . we owe them the money back?
>
> *Mr. Crowley.* Well, no. . . .
>
> *Mr. Hendren. I don't at all!!* I think they have to come and ask me for it.

According to the former Accounting Supervisor, NCAS also abused the Fairfax Hospital claims account. This source told Subcommittee Staff that when the NCAS operating account ran low, she could either let it go into overdraft or move funds from somewhere else. In some cases, she said, she would allow the former to occur, whereupon she would make arrangements with bank officials for coverage until sufficient funds came in. More often, however, she said she would transfer funds from the Fairfax Hospital account, knowing that that account always had $100,000 above and beyond what was needed for routine claims payments. Once the NCAS account had enough funds—typically by the next day—she would move the borrowed funds back to the Fairfax Hospital account.

Neither the former Accounting Supervisor's immediate superior nor, in the latter's absence, Mr. Hendren, ever expressed any opposition to her actions in this regard. The former Accounting Supervisor added that to her knowledge, Fairfax Hospital officials were entirely unaware that its claims account was being used in this fashion.

The Staff found that NCAS managers consistently exhibited a cavalier and often wholly irresponsible attitude toward information in general, and critically important financial data in particular. For example, according to the above-mentioned former Finance and Accounting Department employees, on many occasions they were asked by Mr. Hendren to change the "bottom line" on budget forecast reports, in order to present a more optimistic picture of NCAS's financial situation. In such circumstances, it was expected that they would "adjust" whatever other figures they had to, in order to justify the revised bottom line.

An examination of subpoenaed documents, received from GHMSI, yields an example that underscores the significance of this questionable practice. According to these documents, NCAS's original budget forecast for 1990 showed the company making a small net profit of $6,000 for that year. By June, 1990, however, a net loss of more than $382,000 was posted, and a revised year-end goal was established to keep this net loss from exceeding $500,000. Predictably, and indicative of the pattern resulting from management's attitude toward such data, the final net loss for the year was $988,000.

Another example of this attitude toward information was witnessed by the former Finance and Administration Director when, in her presence, Mr. Hendren picked the year of his birth out of thin air to serve as the number of insured persons on NCAS's TPA contract with another GHMSI subsidiary, EMTRUST. She added that Mr. Hendren did much the same kind of thing in connection with reporting profits earned by NCAS's subsidiary, NCAS/IA. Again, out of thin air, he told his Accounting people to charge back 97 percent of NCAS/IA profits to NCAS for work done by NCAS. Time and again, she said she tried to explain that there was in fact no basis for this 97 percent figure and that there had to be an auditable allocation technique to justify any such transfer of expenses. Mr. Hendren's response to her real concern that there were tax implications to what he was doing in this regard was, "Who's going to catch me?"

Another area where the numbers were manipulated was on the expense side of NCAS's income statement. For example, assets were depreciated in a manner that

depended on the company's financial condition at the time of their purchase. According to the former Finance and Administration Director, this resulted in totally different depreciation schedules for the same asset, which allowed NCAS to manipulate its expense base in a way that made for a better-looking bottom line.

While NCAS has never made a profit, continues to lose money, and is laying off and/or terminating company employees, some managers continued to receive substantial compensation packages and bonuses. For example, NCAS's President, Mr. Hendren, during 1990, when NCAS lost nearly $1 million, he received a $15,000 bonus, on top of his $140,000 salary. During 1991, Mr. Hendren's bonus doubled to $30,000, on top of his $140,000 salary; while in that year, NCAS was losing more than $840,000. In 1991, moreover, Mr. Hendren also received approximately $13,000 in additional compensation for "discretionary" expenses.

An example of the effect, of this and similar practices regarding other managers, on the company's employees was cited in a form filed by the former Accounting Supervisor at the time of her departure from NCAS in November, 1991:

> I have always felt that NCAS' management interests did not lie in the interest of NCAS or its employees. However, in recent months it has become too apparent to ignore any longer. I have heard lies from some members of management and lying is something I find unforgivable. I hear management telling employees that times are tough and we have to cut back. Yet, they still receive perks . . . and bonuses. In my opinion, this is no way to run a company.

Lastly, the Staff discovered that a 1990 audit by the Plan found that NCAS was failing to assign responsibility or take action to verify the accuracy of administrative fees remitted by self-billing clients. The internal auditors found underpayment exceeding 5 percent of the amount owed in two of the three self-billing accounts reviewed (no data were cited in the other case). The audit concluded that since NCAS was not verifying or reconciling the amounts remitted by self-billing clients, there can be no assurance that it is being reimbursed for all subscribers eligible for claim payments.

The significance of this audit finding was underscored when the former Finance and Administration Director told Subcommittee investigators that she informed Mr. Hendren that she also was finding such underpayments. In his Subcommittee deposition, Hendren acknowledged that she emphatically brought this matter to his attention, but he said he refused to believe that this was happening. However, Hendren also admitted that he did not ask about the evidence in this regard and, in effect, simply dismissed her allegations out of hand. Also, on another occasion the former Finance and Personnel Director informed Mr. Hendren that EMTRUST was underpaying NCAS by $3,000 to $5,000 per month; and from all she could determine, he did nothing about that, either.

Such an attitude on the part of Mr. Hendren, the President of a financially troubled firm, not to even attempt to verify if his company was being "underpaid," clearly identifies to the Staff an obvious reason this subsidiary was such a financial drain to the subscribers of GHMSI.

H. *Protocol, Inc.*

The Staff's investigation of Protocol revealed a wholly unnecessary subsidiary which, directly and through its contractual obligations, has been a major financial drain for GHSMI.

Protocol was established to sell health insurance to the foreign embassies and businesses in Washington, D.C.—something BCBSNCA could have done through its own marketing operations, but refused to do because of the unknown risks contained in those sectors. Instead, GHMSI spun off another subsidiary to sell insurance products, and placed the risk in its offshore reinsurance company, NCRe of Ireland. This ridiculous venture has resulted in a major drain of the Plan's reserves, while Protocol's President enjoyed the same—and more—luxuries as his peer subsidiary heads.

Protocol was incorporated on April 22, 1986, in the District of Columbia as a joint venture between GHMSI and Medlantic Healthcare Group. Its charter was amended on May 18, 1988, to reflect 100 percent ownership by GHMSI. Protocol is a stock, for-profit company designed to market and administer health insurance products to the international community in the Washington, D.C., area and other concentrations of foreign clients in the United States; and to market and administer healthcare plans to associations on a nationwide basis.

Protocol grew out of a joint desire by both Medlantic and GHMSI to actively target the foreign community in Washington. Washington Healthcare International (WHIC), a subsidiary of Medlantic, was already involved with this target group as a

provider network. Each party provided $100,000 for initial capitalization. Additionally, a fully extended $988,000 line of credit (LOC) was arranged with Maryland National Bank. The partnership was formed to allow WHIC to be the provider network for Protocol clients, while Protocol would do the marketing, administration, and securing of insurance and reinsurance. The "market" was estimated to be between 75,000 and 90,000 persons in the Washington area alone.

After approximately 1 year, it became apparent that additional funding was required, particularly in the area of marketing. Since WHIC was acting as the provider network only, they declined to front more cash for this operation. An agreement was subsequently reached wherein WHIC forfeited their initial $100,000 investment in return for remaining the provider network for 5 years and retaining a seat on the Board of Directors. They also remained a guarantor on a portion of the initial line of credit. The agreement concerning the Board of Directors was not further renewed after about 1 year.

The Staff has found that at year end 1991, Protocol had accumulated a $6.9 million deficit and with the exception of all but 1990, when a modest profit was made, the company has yearly lost money. GHMSI forecasts a $7 million loss for 1992. These losses are attributed to several factors including lack of competitiveness in the marketplace due to high rates and Protocol's entry into the association business in 1990. A review of financial documents made available to the Staff paints a vivid picture of the mounting losses of the company.

Year	Net Gain/(Loss)	Accumulated Deficit
Dec. 1987	($460,246)	($1,223,074)
1988	($337,286)	($1,560,360)
1989	($816,474)	($2,376,834)
1990	$141;226	($2,235,608)
1991	($4,709,869)	($6,945,476)
1992 (estimated)	($7,000,000)	($13,945,476)

The large loss in 1991 is directly attributed to the financial disaster of Protocol's entry into the association insurance business with the start of a contract with B'nai B'rith. B'nai B'rith is the largest Jewish membership organization in the world, dedicated to promote Jewish continuity. Further details as uncovered by the Staff are provided on this later, but it is first necessary to study the reasons behind the losses prior to 1991.

Protocol's market did not materialize as originally hoped, even though it opened a headquarters on Embassy Row in Washington. The international community targeted by Protocol consisted mainly of embassies and consulates in the Washington, D.C., area as well as foreign-owned companies and international organizations. The embassy business started with the signing up of the Australian Embassy in 1986. Staff review of their client lists showed a diverse group of customers, including: Saudi Arabia, Haiti, Brunei, Malaysia, Belize, Papua New Guinea, Yemen, Israel, and Luxembourg. Protocol's embassy market share was too small to sustain the company.

Hollins Riley, the former President of Protocol, during an interview with the Staff, placed Protocol's losses not on the marketing or administrative efficiency of Protocol, but instead on his company having been hamstrung by having to deal solely with his sister GHMSI subsidiaries. Riley explained that Protocol was not in "risk" or insurance business but instead was a marketing and administrative firm. All the reinsurance on business contracted by Protocol was placed with National Capital Reinsurance (NCRe), a subsidiary of GHMSI.

Protocol, according to Riley, was required by GHMSI policy to place his reinsurance with NCRe, despite claims by Riley that he could obtain the same coverage cheaper from other, non-GHMSI affiliated companies. The high rates he paid to NCRe were coupled with poor actuarial work in assessing the risk. This resulted in NCRe losing money on Protocol's line of business.

Riley complained that some of these actuarial losses were passed back to Protocol because NCRe could not "afford" to reflect the losses on its books or NCRe would have "gone under." Protocol's market share dropped dramatically when NCRe sharply increased its insurance premiums, in turn leaving only the worst-risk cli-

ents willing to pay those rates. In the November 12, 1991, minutes of the meeting of the GHMSI Board of Trustees, Gamble pointed out, ". . . Protocol's losses were attributable to an actuarial miscalculation in computing average claims expense for 1990."

The Staff sees major problems regarding intra-enterprise transactions affecting the financial health of subsidiaries. Had the subsidiaries been financially healthy, the requirement to deal almost solely within the "GHMSI family" might have been beneficial. But as one subsidiary executive put it, the "rubber dollar" that these subsidiaries kept exchanging had to land somewhere. Since all but one subsidiary was a money loser, the accounts receivable and payable for these companies are a morass of uncollectible monies, all ultimately landing on the shoulders of the reserves of BCBSNCA.

Riley contended Protocol was forced to pay Health Management Strategies, World Access, BCBSNCA, and International Consulting Services (all subsidiaries of GHMSI) for various services which could have been done more effectively and cheaply outside the "enterprise." Riley said he was allowed to prove this point once by going outside GHMSI for services, when Protocol purchased its own claims processing system after having experienced high rates and terrible service from National Capital Administrative Services (NCAS), another GHMSI subsidiary.

However, according to Riley, the "real nightmare began" for Protocol in 1991 with the entry into association business with the B'nai B'rith contract. The Staff would have to agree with this assessment as the losses incurred and the problems Protocol encountered with this one contract are phenomenal.

Riley said that in 1990, it became apparent to him that Protocol could not survive dealing in the embassy and international marketplace alone, so he began looking at association business, realizing that strict controls and tight administration would be needed. Giuliani, the current President of GHMSI, told the Staff that he refused to accept association groups at BCBSNCA, because, by the very nature of the business, the insurer could not control the risk being assumed. Giuliani said that it was Joe Gamble who accepted the association risk on behalf of GHMSI.

Riley, in hindsight, stated that a variety of mistakes were made when they entered into this contract. The critical one, he said, was that of all associations, B'nai B'rith is probably the most complex. They have members in 49 States and offer 11 lines of business. Protocol lacked the experience and resources to handle this type and amount of business. In addition, Protocol's claims system was inadequate.

Riley said that 3 months of discussions were held between Protocol and B'nai B'rith prior to signing the contract. He said Gamble and Giuliani agreed to the deal, as long as reinsurance could be obtained outside the company. Lloyd's of London agreed to reinsure part of the risk, and the contract was signed. A June 6, 1990 letter from Protocol to B'nai B'rith assures the client that BCBSNCA stands behind the company:

> Should Protocol not be ready or able to perform the administrative and customer servicing as is its contractual obligation, Blue Cross Blue Shield of the National Capital Area would assume Protocol's duties under the terms agreed to between Protocol and B'nai B'rith. Having made this commitment I can assure you that Protocol, through it's own resources or those of the Enterprise, will be ready to accept B'nai B'rith's new insureds as of October 1, 1990.

Riley said he was depending on GHMSI and specifically Health Management Strategies and International Consulting Services to manage the contract by providing accurate consulting and actuarial work. But GHMSI had no experience in this area either. This is abundantly clear as both National Capital Reinsurance and International Consulting Services studied the proposal prior to Protocol entering into the agreement, and both companies agreed that the business would be profitable.

Protocol was also depending on GHMSI's strength and the entire Blue Cross and Blue Shield system of local provider networks to utilize this product. But this never materialized, for when other BCBS Plans were asked to participate, they refused, as, according to Mr. Riley, "GHMSI's name was mud" with the other Plans. GHMSI's trademark fight with the National Association had soured the other Plans to the point where they would pass up potential profits just to deny GHMSI the same. This forced Protocol to use three different companies in order to cover the client in all 50 States. The resulting extensive administrative headaches and expense for each facet of administering the B'nai B'rith contract required coordination and action with many different companies. Nothing was standardized, as three different U.S. insurance carriers produced different cards, pamphlets, and forms. Overhead and admin-

istrative expenses soared, as Insurance Department approval was needed in every State.

The very nature of the B'nai B'rith contract raises serious questions and concerns. B'nai B'rith was guaranteed $3.8 million every year for 5 years in return for Protocol getting the business. This guarantee came in the form of $2 million per year plus $880,000 to cover expenses of B'nai B'rith's branch offices, national office, and broker expenses involved in the sale and administration of the insurance to the members. There was also a guarantee of $120,000 per year to help pay for advertising expenses associated with marketing the insurance. If more than $2 million was obtained by Protocol, then B'nai B'rith also received 10 percent of new business premiums and 5 percent of renewal business. The $3.8 million was paid to B'nai B'rith regardless of how much Protocol made.

Riley said it is a common practice in association business to pay money to the association for the contract, normally a one-time payment, with perhaps future payments when the contract is renegotiated. He said it was not common to guarantee this income over a 5-year period. Riley said that based on the amount of business B'nai B'rith had, he thought this would grow into an $800,000 profit, at the same time expanding GHMSI's business.

However, members purchasing insurance dropped when the account changed hands from Mutual of New York to Protocol, and rate increases were imposed on the client after the first year of the Protocol contract. Although the overhead remained the same, income dropped; and Protocol never received enough income to cover the $3.8 million guarantee to B'nai B'rith. It was a loser from day one, and GHMSI is now projecting over $12 million in 1992 losses for this contract alone.

Protocol's other two association clients were not handled the same way. United Way requested only 2 percent of commissions, and the Korean American Chamber of Commerce also received money through commissions. The United Way account was a money loser, too. Protocol had expected to sign 10,000 persons, but because of problems at United Way, only 600 to 700 were enrolled. United Way's contract was canceled in 1992.

The Staff concludes that GHMSI did not know what it was doing when it entered into the association business, directly causing losses to Protocol and GHMSI of millions of dollars.

A GHMSI internal audit of Protocol was conducted in 1991, revealing serious problems including: lack of written policies and procedures; lack of written contracts; lack of consistent approval in travel and expense report for the President and Vice President; problems with accounts payable and receivable; three different billing systems used for the B'nai B'rith account; accounting problems in journal entries; and the inability to accurately assess underwriting gains and losses for Protocol paid claims. Specifically, the auditors reported:

> Protocol's current accounting procedures are not in keeping with GHMSI intercompany practices and do not provide a clear understanding of Protocol's financial position.

It is curious to note that Riley told the Staff that the keys to profitability in association business were tight controls and administration. The audit showed the exact opposite existed at Protocol. The Staff also notes that some manner of self-delusion existed in GHMSI about Protocol, as is evident in the minutes of a November, 1991, Strategic Planning meeting:

> Mr. Gamble indicated that Internal Audit has been providing him a monthly status report on Protocol's performance and there have been no major problems. In addition, Internal Audit conducted a full audit of Protocol and while there were a number of recommendations that are currently being implemented, there were no serious problems. Mr. Gamble is concerned with the spread of unsubstantiated rumors concerning Protocol and said that Protocol does not have any serious problems.

In spite of Mr. Gamble's assurances, the Staff found that Protocol received a virtual flood of complaints from B'nai B'rith subscribers about the lack of service provided by Protocol. Relations between GHMSI and B'nai B'rith got so bad that GHMSI tried to smooth things over by holding an "Executive Retreat" in Lanai City, Hawaii, involving the leadership at B'nai B'rith, the key players in Protocol, GHMSI, National Capital Insurance Agency (NCIA), and North American Life and Casualty Company (NALAC).

The trip was held from January 25, 1992, through February 2, 1992. Protocol paid for the majority of the expenses, including those of the GHMSI spouses. Hotel expenses totalled $32,645.27, and airfare paid for by Protocol cost $14,179.12 (the

NALAC participants paid for their own airfare, but their spouses were paid for by Protocol).

While Riley billed this as a working trip, golf, deep sea fishing, sailing, and a trip to Maui were also on the agenda. A review of the agenda reveals that although participants started arriving on January 25, 1992, the first meeting was held on January 29 from 8:30 to 11:30 a.m. Only three, 3-hour meetings were held over the 9 days participants were present. The Staff questions the propriety of these expenditures in light of the substantial losses incurred by Protocol and the financial condition of its parent.

This trip was not the only extravagance Protocol was involved in. Detailed elsewhere in this report is Protocol's expenditures connected with the Gold Cup, an annual steeplechase event held in Virginia. Only recently did GHMSI attempt to lower its costs from the event by permitting another company to take the Gold Cup sponsorship tent at no cost to that company. Protocol also paid over a thousand dollars for its President's purchase and storage of wine at "Morton's of Chicago," at Tysons Corner, despite posting millions of dollars of losses. Gamble knew this, as he lunched and drank at Morton's with Riley. A review of Protocol's local Travel and Expense Reports reveals Riley lunched frequently with members of his own staff, charging the entire bill to Protocol. This conduct occurred at a time when both Gamble and Riley were well aware of GHMSI's continued financial deterioration.

Protocol, like all the other subsidiaries, had no external direction or oversight by an independent Board. Gamble was Protocol's Chairman of the Board. Riley told the Staff that when a vote was taken at the Board meeting, all the Board members would look at Gamble and vote as he did. When Gamble raised his hand, they all followed suit. Gamble apparently was aware of this, for at one meeting he started to raise his hand and then brought it down to his face as if to wipe it. Riley said the same gesture was repeated by the other Board members, who thought Gamble was going to raise his hand.

In conclusion, Protocol's losses were the result of poor business decisions and a prevailing attitude to keep business within the "enterprise." The Staff questions whether proper due diligence was performed before entering into association business which caused the majority of the losses at Protocol.

I. *World Access and Access America*

The Assistance Group, which included World Access and Access America, was one of the largest ventures by GHMSI and, as the Staff discovered, one of the biggest financial drains upon the Plan. From its creation on July 1, 1983, it expanded to include over 14 other affiliated or subsidiary companies operating across the globe, which provided products as varied as worldwide emergency medical services and lost baggage and trip interruption insurance.

In the course of its existence, the Assistance Group, which includes World Access and Access America, has consistently lost money for the Plan and accumulated over $32 million in losses for the subscribers of the D.C. Blue Cross and Blue Shield Plan.

This particular operation has been involved in significant losses for years and continues to be unprofitable to date. Its projected operating losses for year-end 1992 are $5.5 million. In a November 13, 1992, letter from Mr. Peter O'Malley, the Plan's new Chairman of the Board, to the Virginia Insurance Commissioner, Mr. O'Malley stressed the dire state of this subsidiary:

> World Access International . . . continues to lose money and is currently in a severe cash crisis. They are also projected to continue losses on a going forward basis. . . .
>
> Due to World Access International's cash crisis, it is possible that this subsidiary could become insolvent and be put out of business in the next few weeks unless funds are advanced. . . .

The Staff has reviewed thousands of pages of financial records and management documents from World Access, as well as interviewed dozens of witnesses in an attempt to ascertain how and why GHMSI, a relatively small, domestic Blue Cross and Blue Shield Plan, chartered by Congress to provide low-cost health care coverage to the citizens of the District of Columbia, would ultimately develop operations in countries as far away as Singapore, New Zealand, Australia, and New Guinea.

While the Staff's analysis of World Access may provide some answers to this question, in the course of doing so, it has also raised others, including:

—the propriety of creating a joint venture with an individual who retains a 49 percent interest in World Access and, accordingly, a potential for 49 percent of the profit even though he made no financial contribution to the venture and bore no financial risk;

—the potential conflict of interest of having a Senior Vice President of GHMSI also be an Officer, Director, and 49 percent owner of World Access, a subsidiary of GHMSI;

—the propriety of management rapidly investing Plan assets in international ventures without prior experience or adequate due diligence review;

—the soundness of continual investment of Plan resources into a consistently losing venture; and

—the ultimate fiduciary duty of officers and trustees to ensure the finances of a Blue Cross and Blue Shield Plan be spent in the best interest of the policyholders.

World Access is a joint venture between GHMSI, which owns a 51 percent interest, and Dr. Sol Edelstein, who owns a 49 percent interest. This venture started in 1983 with a $500,000 contribution of capital from GHMSI. Dr. Edelstein made no capital contribution to World Access but, rather, contributed the "idea" and stock from its forerunner.

To service its customers, World Access maintains an international and domestic health care network of hospitals, medical advisers, and medical transport firms. A communications infrastructure links this extensive global network for immediate action anywhere in the world.

World Access, Inc., also markets retail and group travel services which include assistance for trip interruption, lost baggage, travel accidents, as well as a 24-hour hotline for assistance with medical emergencies. Its business structure evolved into three divisions; group travel, retail travel, and bank card enhancements. Foreign subsidiaries generally acted independently and supported the strategic plan for international travel assistance. (See Appendix C for World Access's subsidiaries.) The original concept was to plant the BCBSNCA flag internationally; however, a successful lawsuit brought against GHMSI by the Blue Cross and Blue Shield Association in 1989 ended GHMSI's use of the BCBS logo and trademark in the international market, but not its subsidiary activity.

The Staff reviewed the financial statements and supporting documents of World Access and its subsidiaries and found a disturbing pattern of nonprofitability, apparent overbilling of other GHMSI subsidiaries, assets which consisted primarily of impaired subsidiary receivables, loans made or guaranteed by GHMSI, and findings by auditors which stated World Access's continued existence was dependent on the financial support of GHMSI. Illustrative of this review are:

—By the end of 1985 after 2 full years of operations, independent auditors found World Access was dependent on GHMSI for its economic survival. By this time, World Access had borrowed $1,000,000 on an unsecured line of credit posted by GHMSI on January 16, 1986, GHMSI arranged for a secured bank loan guaranteed by GHMSI for $2,000,000. World Access had an accumulated deficit of ($1,793,467).

—For year end 1986, independent auditors found World Access to be financially dependent on GHMSI. Approximately 68 percent of all revenues came from transactions with related parties, primarily Access America. Significant overcharges were also noted in the financial reports. For example, Access America was charged $313,961 by World Access, while the cost of the services amounted to only $90,069. The Staff questions the apparent overcharging of Access America, which was at that time a joint venture between GHMSI and Empire BCBS, New York. Liabilities included a $2,103,000 demand note guaranteed by GHMSI and an accumulated deficit of ($2,601,427).

—For 1987, the independent auditors found World Access to be dependent upon GHMSI's assuring its financial security. Approximately 80 percent of the revenues were derived from related subsidiaries. Again, a pattern of overcharging of its subsidiaries was noted, e.g., Access America was the largest source of revenue at $1,182,772, although World Access's cost of this service was only $222,444. The accumulated deficit was ($2,692,375).

—In 1988, the independent auditors again found that the financial viability of World Access was dependent on continued GHMSI financial support and capital contributions. Again, there appeared to be significant overcharges to GHMSI affiliates, e.g., Access America was billed $1,968,821 for services costing $425,257; other services, the majority of which were GHMSI affiliates—such as CapitalCare, International Assistance, Claims and Service Centers, and Blue Cross International—were charged $1,238,120 at a cost to World Access of $117,716. The largest expense was personnel, which jumped to $1,536,939 from $946,516. The accumulated deficit was (2,735,367).

—On August 3, 1990, GHMSI acquired 100 percent ownership of Access America. Prior to that, it held 40 percent, while Empire New York held the remaining 60 percent. The 1990 balance sheet for World Access and its subsidiary reflected assets of $18,465,913, an increase of over $15 million from the prior year. These assets include notes receivable from Access America of $5,143,862; furniture, $4,796,399; and an interest-free note from Access America for $4,740,000. These three items accounted for 79.4 percent of all of World Access's assets. At that time Access America was also determined to be financially dependent on GHMSI for its continued existence. Thus, the majority of World Access's assets were debts owed by or loans to one of its sister subsidiaries, Access America, which was itself financially dependent on GHMSI. Again, a review of the revenue and cost of services shows wide gaps. Access America was charged $10,322,090 by World Access for services which cost $1,842,293; other services (primarily to affiliates) were billed at $6,558,872 and cost World Access only $1,697,696. Personnel costs skyrocketed to $7,181,740.

—Total liabilities were $20,308,754, of which $2,999,990 was a bank note guaranteed by GHMSI; $7,890,991 due GHMSI; $1,481,768 due Access America; and an additional $4,740,000 was due GHMSI for a long-term loan to Access America. These liabilities come to almost 85 percent of all liabilities. Stockholders' equity reflected an accumulated deficit of ($2,007,623).

—In 1991, an independent audit of the consolidated balance sheet of World Access determined it was dependent on GHMSI for its continued financial existence. The auditor's report indicates that there were $15,582,946 and $10,322,090 in revenues derived from affiliates in 1991 and 1990, respectively, at a cost of only $1,301,296 and $1,842,293, respectively. Stockholders' equity reflected an accumulated deficit of ($2,576,339).

—By year end 1991 the Assistance Group was $32,148,616 in the red and climbing.

The Staff has discovered that Access America caused most of the Assistance Group's losses ($29.5 million). Access America began as a joint venture between Empire BCBS of New York (60 percent participant), and GHMSI (40 percent participant), to enter the travel services area. The start-up costs were provided by paid-in capital and lines of credit guaranteed by both Plans.

Access America was originally to be a wholly owned subsidiary of the Empire Plan—until Gamble and Edelstein discovered World Access was about to have competition from another Blue. Gamble quickly struck a deal with Empire to share in Access America and, thus, was able to control—to some extent—the competition. Unfortunately for the DC Plan, it did not pay close attention to Access America's clients.

The Assistance Group's single largest disaster involved Access America's contract with a tour operator, American Leadership Study Group (ALSG).

In early 1986, Access America approached ALSG to sell trip cancellation insurance which was underwritten by BCS Financial Corporation. BCS Financial is an amalgam of 55 Blue Cross Plans which included Empire and GHMSI. The trip cancellation policy as designed by Access America and BCS did not have any provisions for tour owner default. Access America and its underwriter, BCS, could be held liable by individual travelers if the tour defaulted. In the fall of 1986, ALSG collected deposits from students for travel in the summer of 1987. ALSG was owned and operated by Mr. Gilbert S. Markle.

Unfortunately, ALSG was, at best, mismanaged, and, at worst, as alleged by GHMSI, the victim of alleged internal embezzlement. The Staff has been told by several sources associated with GHMSI that Markle spent the tour group's receipts on a lavish lifestyle instead of securing the future trips he had booked, leading to a Ponzi scheme. Unfortunately, because of heightened international terrorism at the time, business fell off, and Markle ran out of money.

By summer 1987, American Leadership Study Group was in dire financial trouble, and it appeared the summer tour might be canceled; if that happened, Access America and BCS Insurance would face significant trip-cancellation losses for the approximately 4,000 tours booked approximately ($8,000,000). On June 8, 1987, to prevent an ALSG default, Access America guaranteed $2.5 million in letters of credit or cash advances, including a $750,000 cash advance by BCS. In exchange, Mr. Markle secured these loans with his real estate and personal property.

By early 1990, faced with ALSG losses of over $11 million, senior management of Empire and GHMSI intervened in the ALSG situation. Dr. Edelstein, President of World Access and Board member of Access America, began, at the direction of the Access America Board, an investigation into the management and financial viability of Access America. The investigation led to Access America's assuming possession of

deeds, stocks, and control over accounts from Mr. Markle on May 15, 1990, and Access America employees assumed control of ALSG as "creditor in possession." An analysis of ALSG books and records by Peat Marwick indicated significant problems including a $1 million liability not reported on the 1989 financial statements prepared by ALSG.

On August 3, 1990, GHMSI acquired 60 percent ownership of Access America from Empire BCBS for a release of $1,909,906 in accounts payable owed to Empire, $885,000 in debt was effectively released as Access America incurred a non-interest bearing promissory note of $3,630,000 due in annual installments. Empire got off the hook easily, because GHMSI needed to maintain Access America to support World Access's operations.

GHMSI believed they now had clear title to Markle's assets. These assets included a recording studio, in which the Rolling Stones, Aerosmith, and other top rock and roll bands played; a boathouse on Cape Cod; and a single-family home in which Mr. Markle's children were living. The DC Plan was now in the student tour, real estate, and music business.

A new purchaser, Mr. Sam Cooper, was introduced to GHMSI by Mr. Markle. Negotiations were quickly completed between Mr. Cooper and Mr. Gamble over the objections of Sol Edelstein. Dr. Edelstein believed Cooper's bona fides needed further examination. According to Charles Duvall, then Chairman of GHMSI's Board, "Sam Cooper was an exception to due diligence."

On March 15, 1991, GHMSI completed a sale of Markle's assets to Mr. Cooper who claimed to represent La Jolla University and collateralized his purchase with a charitable trust, Unitrust, whose assets allegedly exceeded $100 million. Shortly after the sale, Mr. Cooper allegedly began to manipulate assets of ALSG, which caused an estimated $1.2 million loss; and to dismiss key employees. When Cooper's first loan payment came due on June 1, 1991, Cooper defaulted. In pursuing repayment, GHMSI discovered that La Jolla University denied any knowledge of Cooper's activities on their behalf.

The GHMSI staff also discovered that a 1991 student tour was not properly funded and could have led to substantial losses due to trip cancellation insurance and considerable bad will on the part of the stranded students. GHMSI stepped in to financially rescue ALSG for the last time, with an infusion of cash to cover the 1991 tour season.

The total cost to Access America for the ALSG fiasco is well over $14 million, which included $1.7 million in legal fees; and continuing legal expense will drive the price higher. The episode clearly displays a lack of prudent management action which did not reflect the best interests of the subscribers.

As a 49 percent owner of World Access, a stock for-profit subsidiary of GHMSI, Dr. Edelstein was promised almost half of any dividends paid. World Access never made a profit, but Dr. Edelstein enjoyed job security, international travel, and a six-figure salary while the subscribers continued to shore up the exploits of the Assistance Group.

Dr. Edelstein's minority interest in World Access and his position as officer of GHMSI prompted the Virginia Insurance Department to find Dr. Edelstein in violation of Virginia statutes which prohibit officers of health services plans from, personally or through businesses in which they have a substantial interest, receiving loans from the plans. As of December 31, 1991, World Access owed GHMSI $12,018,745.

Following the notification by the Insurance Department, Dr. Edelstein stepped down as a GHMSI officer but remained a President of World Access.

V. FEDERAL PROGRAMS

The Subcommittee Staff found problems similar to those described elsewhere in this statement regarding BCBSNCA's involvement in Federal health insurance programs, including the Federal Employees Health Benefit Program (FEHBP) and Medicare. Specifically, the Staff found that BCBSNCA's handling of its Federal programs responsibilities was replete with instances of inadequate performance and questionable business judgment. These persistent and pervasive flaws in BCBSNCA's operations have resulted in tens of millions of dollars in losses, as well as the loss of tens of thousands of subscribers and corresponding market share.

A. *Removal of BCBSNCA from Medicare*

One of the areas in which the Staff found major management problems was in BCBSNCA's handling of the Medicare contract for the Washington Metropolitan area. BCBSNCA's "poor performance" in this regard caused the Department of

Health and Human Services, Health Care Financing Administration (HHS/HCFA), to remove it from the Medicare Contract as of March, 1988.

Medicare is the Federal health insurance program that covers most Americans 65 years of age or older, and certain Americans under 65 years of age. It consists of two parts: Part A, Hospital Insurance for the Aged and Disabled, which covers services furnished by hospitals, home health agencies, hospices, and skilled nursing facilities; and Part B, Supplementary Medical Insurance for the Aged and Disabled, which covers physician services and a range of related, non-institutional services.

HCFA is responsible for administering Medicare by, among other things, establishing regulations and policies and issuing guidance to health care providers and contractors involved in the program. It contracts with private insurers to process claims and operate the program on a day-to-day basis. HCFA can renew the Medicare contracts annually, without regard to Federal laws that require competitive bidding. HCFA refers to Part A contractors as "intermediaries," and Part B contractors as "carriers."

In 1966, BCBSNCA/GHMSI and HCFA signed their first Medicare Part A agreement. This contract, which was automatically renewed until 1984, gave them the exclusive right to continue as the Medicare intermediary for the Washington area, with no fear of competition.

The Staff has learned in the course of its review that, historically, contracts of this nature were routinely renewed, primarily because HHS had no authority to remove a contractor for poor performance. In 1984, in response to concerns expressed about this situation, Congress provided such authority to HHS by allowing it to remove contractors performing in the lower 20th percentile of those participating. HCFA subsequently established procedures and criteria for evaluating contractor performance—the Contractor Performance Evaluation Program (CPEP) and the Annual Contractor Evaluation Report (ACER).

Very little concern about BCBSNCA's performance was expressed by HCFA until the mid-1980s, when a pattern emerged that led HCFA to conclude that BCBSNCA was not living up to the standards established for Medicare contractors. Indeed, according to the Annual Contractor Evaluation Report rankings, BCBSNCA's performance had declined precipitously between 1984 and 1986—from 28 out of 65 in 1984; 41 out of 61 in 1985; to 54 out of 57 in 1986.

In the 1986 evaluation report, for example, BCBSNCA failed CPEP criteria in the critically important areas of payment safeguards/provider reimbursement and fiscal/contract management. Pursuant to these findings, in February, 1987, BCBSNCA was formally notified that its Medicare Part A contract would not be renewed.

The removal of a Medicare contractor is a very rare occurrence—just two contractors were removed prior to 1987, and none have been removed since BCBSNCA was removed in 1987. BCBSNCA contested this decision in every possible way, including filing suit to have it reversed. While these efforts were unsuccessful, they did result in what the Staff believes were "face-saving" concessions from the Government that made it appear that BCBSNCA was voluntarily leaving the Medicare program.

It is also instructive to note that even some BCBSNCA officers and the GHMSI Board of Trustees were misled about the true situation concerning their loss of the Medicare Part A contract. For example, as late as May 6, 1990, according to the Board of Trustees Meeting Minutes, Mr. Gamble tells the Board that BCBSNCA:

> . . . got out of the Medicare business in an attempt to save money . . . [because it] was unable to recover its total cost.

Gamble never mentioned the Plan's poor performance or HHS's reasons for wanting BCBSNCA out of the program. The extent of this misrepresentation of the facts was further confirmed by the Subcommittee Staff in interviews with the former GHMSI Chairman of the Board and the current GHMSI Chief Financial Officer, both of whom said that as far as they knew, BCBSNCA had voluntarily left the Medicare program because it was unprofitable.

The adverse effects of the loss of the Medicare Part A contract on BCBSNCA have been numerous and significant. For example, at the time they lost the contract, BCBSNCA was receiving more than $2 million per year in service charges for processing nearly 500,000 in claims, involving benefits totaling over $500 million. Using these data, it is safe to estimate that BCBSNCA has already lost many millions of dollars in potential income as a result of its removal. Moreover, since BCBSNCA could have continued to participate without any realistic competition for the foreseeable future, but for its poor performance, underscores the long-term financial implications of this situation.

In addition, as a result of the removal, and the attendant loss of enrollments it entailed, BCBSNCA also lost critically important leverage with providers. According to HCFA documents, over 100 institutional providers were servicing Medicare recipients in hospitals, skilled nursing facilities, and home health agencies at the time the contract was terminated. The significance of this lost bargaining power lies in its importance as part of BCBSNCA's overall business strategy to obtain concessions from providers by "selling" the fact that, as the biggest plan in the Washington, D.C., area, they could guarantee a volume of business beyond that of its competition. In effect, the Medicare contract gave BCBSNCA the ability to negotiate lower charges on medical services performed by providers, thereby helping to make this, as well as other lines of the Plan's business, profitable.

The loss of the Medicare contract also generated some adverse publicity. For example, in a July 4, 1987, Washington Post article, an HCFA Associate Administrator explained why HHS had taken the adverse action against BCBSNCA by pointing out that the latter's performance had "deteriorated rather sharply" in recent years. For BCBSNCA, such adverse publicity translated into a loss of prestige within the health care community and Blue Cross Blue Shield system. That they no longer have this important contract in one of the nation's most highly visible markets is, in the words of BCBSNCA's current Chief Financial Officer, a "major blow" to the company.

B. *FEHBP Losses*

The Federal Employees Health Benefits Program (FEHBP) provides voluntary health insurance coverage for approximately 9 million Federal employees, retirees, and dependents. The total cost of the FEHBP for Fiscal Year 1992 was estimated at $14.5 billion. The program is financed jointly by the Government and enrollees through premium payments. The FEHBP is administered by the Office of Personnel Management (OPM), which is responsible for: approving plans for participation; negotiating with plans to determine benefits and premiums for the following year; coordinating premium payments; and making information available on the various plan options.

BCBSNCA, in some fashion, has participated in the FEHBP since the latter's inception in 1966. Currently, it is one of about 400 plans that participate in the FEHBP. Pursuant to this involvement, BCBSNCA covers about one million Federal employees, retirees, and their families (about 12 percent of the total covered by all participating BCBS Plans) in the greater Washington, D.C., Metropolitan area. This constitutes about 40 percent of BCBSNCA's overall group business. According to OPM, in 1992, BCBSNCA serviced 201,959 contracts under the FEHBP, down from 294,368 in 1980. The total paid claims were nearly $600 million, which generated more than $39 million in administrative expenses billed to OPM for the same period.

BCBSNCA is or has been involved in all three of the major types of FEHBP plans, including:

—*Government-wide Plans*, which are open to all Federal employees, retirees, and their families. Currently, there is only one such Plan, the Service Benefit Plan, which is administered by the Blue Cross and Blue Shield Association. BCBSNCA is the largest participant in this Plan.

—*Employee Organization Plans*, which are sponsored by employee organizations or unions for their employees, retirees, and their families. In 1991, there were 14 such Plans in the FEHBP, seven of which were open to all Federal employees. As of 1992, BCBSNCA had contracts with several employee organizations, including the:

* National Alliance of Postal and Federal Employees (Alliance Health Benefit Plan), covering 24,450 enrollers, plus an estimated 21,000+ dependents.

* Beneficial Association of Capitol Employees (BACE Health Benefit Plan), covering 8,970 enrollers, plus an estimated 6,000+ dependents.

* National Association of Postmasters of the United States (NAPUS Health Benefit Plan), covering 8,749, enrollers, plus some 12,000+ dependents.

* U.S. Secret Service Employees Health Association (SSEHA Health Benefit Plan), covering 2,594, enrollers, plus some 3,500 dependents.

* National Treasury Employees Union (NTEU Health Benefit Plan), covering 7,969, enrollers, plus some 9,000+ dependents.

—*Comprehensive Medical Plans* (Health Maintenance Organizations or HMOs), which provide or arrange for health care by designated Plan physicians, hospi-

tals, and other providers in particular geographic locations. There are about 300 HMOs in the FEHBP. BCBSNCA's HMO, CapitalCare, left the FEHPB in 1991.

Subcommittee investigators found that in recent years BCBSNCA has suffered major losses in several areas of its FEHPB business, and that the combination of these has adversely affected the company's overall profitability and financial soundness.

(1) *Alliance Health Benefit Plan*

This Plan was described by a senior BCBSNCA official as "the largest and healthiest" of all the FEHBP Association Plans. It was sponsored by the National Alliance of Postal and Federal Employees (Alliance) and in 1992 had a total enrollment of about 46,000 employees, retirees, and their dependents. BCBSNCA started underwriting the Plan in 1989; but, after negotiations recently broke down, Alliance decided to contract with Aetna, beginning in January, 1993.

According to OPM and Alliance officials, Alliance lost interest in staying with BCBSNCA when the latter refused to explain and/or provide adequate information regarding a number of billings and other important financial issues. For example, BCBSNCA tried to force a major change in its favor, by insisting on an adjustment in the formula regarding administrative fees paid by OPM, from the existing 85 percent BCBSNCA/15 percent Alliance split, to a 95 percent/5 percent ratio.

In addition, an Alliance official told Subcommittee Staff that BCBSNCA tried to bill their Plan $50,000 for travel expenses—something that did not make much sense given the fact that both organizations are located in Washington D.C. Commenting on this bill, the Alliance official quipped, "That's a lot of cab rides." Perhaps as important, when Alliance requested more details about this bill, BCBSNCA was not forthcoming in its response.

Also, BCBSNCA requested unrestricted and unquestioned access to Alliance's reserves. When asked for an explanation of this request, BCBSNCA refused to respond. In short, even in the face of protracted efforts by OPM and Alliance to resolve these serious questions, Alliance's President said that he felt he had no choice but to break off negotiations with BCBSNCA, because it had simply become "impossible to deal with." A letter from James McGee, the Alliance President, detailing their problems with the contract will be introduced as a separate exhibit.

The effect of losing this large and important account is similar to what happened when BCBSNCA lost the Medicare contract in 1987: significant losses in income (e.g., approximately $19.5 million in service and administrative charges in 1992); a reduction in subscribers that will further erode BCBSNCA's ability to entice providers' participation because of enrollment volume; and the accompanying loss of prestige in an ever-tightening and competitive marketplace.

(2) *NTEU Health Benefit Plan*

Sponsored by the National Treasury Employees Union, this Plan had an enrollment of approximately 17,000, including dependents. BCBSNCA started underwriting it in 1989, but terminated the contract in 1992, after sustaining some $20 million in losses. BCBSNCA and OPM officials said the contract went into what is described as a "death spiral," i.e., a 40 percent rate increase, in response to high losses already incurred, caused more than 50 percent of the Plan's subscribers to move to other Plans during a 1-year period.

The sizable loss on the NTEU Plan after only 3 years prompts the related question of why BCBSNCA wanted the contract in the first place. According to OPM officials, Mutual of Omaha dropped this Plan at the end of 1988, because they were not making enough money on it to make it worth their while to continue. While it is difficult to determine whether BCBSNCA did sufficient due diligence before entering into this contract, it should be noted that NTEU has been unable to find an underwriter since being dropped and, therefore, as of this time is no longer participating in the FEHBP.

(3) *CapitalCare*

CapitalCare's HMO entered into the FEHBP in 1985, and at its peak had about 8,500 subscribers. It withdrew from the FEHBP at the end of 1991, after steadily losing money and subscribers for several years. Overall losses sustained by BCBSNCA in this regard range in the many millions of dollars. For instance, according to CapitalCare's former President, in 1988 the HMO lost $10.2 million, a significant portion of which he attributed to its FEHBP operations.

OPM and BCBSNCA officials cited a number of reasons for the sustained losses that led to this HMO's withdrawal from the FEHBP, including:

—BCBSNCA failed to properly fund and/or manage this new venture. One OPM official, for example, told the Staff that he thinks BCBSNCA did not do what was needed to "sell" its HMO product to the public and providers, alike.

—BCBSNCA entered into this highly competitive line of business several years after other well-established and aggressive HMOs, such as Kaiser Permanente and the George Washington University Health Plan, had already signed up many of the young, healthy families interested in this option.

—BCBSNCA's late entry and the reduced number of young, healthy families to draw from, caused CapitalCare to get more than its fair share of less-healthy enrollees, who required more and higher cost care. Under OPM "open plan" contractual requirements, all participating HMOs have to accept all Federal employees, annuitants, and their dependents regardless of their health or previously existing conditions.

Thus, as the following chart illustrates, BCBSNCA has lost a total of 40,219 enrollees, or approximately two thirds of its enrollees in their association enrollment.

Association Enrollment Losses Federal Employee Health Benefit Program Blue Cross Blue Shield National Capital Area

Source: OPM

	Enrollees Only	Including Dependents*
* National Alliance of Postal and Federal Employees	24,450	45,799
Beneficial Association of Capitol Employees	8,970	14,927
* CapitalCare	7,800	11,790
National Association of Postmasters of the United States	8,749	21,056
* National Treasury Employees	7,969	16,696
U.S. Secret Service Employees Health Association	2,594	6,057
Totals:	60,532	116,325
* Enrollees Lost, 1991–1992	(40,219)	(74,285)
1993 Totals without Alliance, NTEU, and CapitalCare	20,313	42,040

+ Dependents are estimated by OPM at 2.50 times the number of single enrollees in a Plan. Enrollee figures include retirees.

C. *Questionable Billing Practices*

During the course of its investigation of the role BCBSNCA plays in the Federal employee health insurance programs, the Subcommittee Staff learned of a matter that bears directly upon the National Blue Cross/Blue Shield Association (National Association).

Specifically, in reviewing recent audits by the OPM Inspector General (OPM/OIG), we came across a questionable charge to OPM by the National Association, which we believe may be indicative of the problems faced by the Government in its dealings with this contractor.

Briefly, this charge came as a result of the contentious and protracted legal battle between BCBSNCA and the National Association. As previously described in this statement, this litigation resulted when BCBSNCA decided to expand overseas, registering the Blue Cross and Blue Shield trademarks abroad. While the National Association, which retains control of the logos and name, objected to this activity, BCBSNCA continued undaunted. In the suit, the National Association prevailed, forcing BCBSNCA to cease using the name and service mark abroad.

According to the National Association's counsel, it spent—for external legal counsel alone—"over $2.2 million" in its lawsuit against the DC Plan, which was brought in 1989. According to the OPM/IG audit, the National Association charged the Federal Government for a substantial portion of these legal expenses—over $343,000 in 1990 along.

While this amount pales in comparison to the remainder of the costs questioned in the audits—over $16 million—the Staff was concerned to find the Association billing the Government for an internal squabble with one of its member Plans.

The Staff continues its separate investigation of contracting by the Federal Government and the National Association.

VI. ADMINISTRATIVE EXPENSES

When the Subcommittee began its investigation into GHMSI, the Staff was alerted to several areas within the corporation that, based upon the Subcommittee's prior Blue Cross and Blue Shield investigations, appear to particularly lend themselves to potential abuse. The Subcommittee found in the course of its West Virginia and Maryland investigations that salaries, fringe benefits and other administrative expenses were three particular areas where abuses were noted.

The Staff's review of GHMSI appears to show similar questionable expenditures. The Staff found excessive spending and outright waste to be rampant throughout GHMSI. Limousines, five-star resorts, exorbitant gifts, expensive hotels, extravagant dining, exotic travel, commissioned artwork, country club memberships, and golf outings, all at a cost to the subscriber, are but a few of the expenditures that the Staff will outline here today.

As the Subcommittee Staff does so, we note that none of the excessive expenditures discussed are illegal. However, they all were incurred at a time when BCBSNCA subscriber rates were increasing, subscriber benefits were decreasing, and the net profitability of the D.C. Plan was shrinking.

A. *Executive Salaries and Compensation*

Joseph Gamble assumed the position of President and CEO of GHMSI in 1985. The first records that the Subcommittee found concerning Gamble's compensation from GHMSI, begin in 1987. His total compensation for that year was $264,487. In 1991, just 4 years later, his total compensation was $533,589. This represents an increase of 102 percent. The Staff has prepared a chart comparing the salaries and benefits of the top eight executives versus all other GHMSI employees. It is attached as Appendix F. As the Subcommittee's chart reveals, this jump in executive salary was not unusual for those in top positions at GHMSI. From 1988 to 1991, the salaries and benefits of the top eight executives of GHMSI rose nearly 85 percent, while the remaining employees of the Plan received only a 13.2 percent increase during this same period.

The Subcommittee has also prepared a chart that shows the compensation histories of these same top eight executives. It is interesting to note that while Gamble's total compensation rose 73 percent from 1988 to 1991, his was not the greatest increase. Four other executives of GHMSI, Wright Poffenberger, Dick Groppe, Ben Giuliani, and S.J. Pace, all had compensations that rose at greater rates than that of the President of the parent corporation. (Chart below)

GHMSI—Executive Compensation

(Based on information provided by GHMSI)

	1988	1989	1990	1991	Percent increase *
Gamble	308,156	353,589	418,866	533,589	73%
Giuliani	235,074	254,370	364,778	460,947	96%
Poffenberger	111,967	127,535	150,744	204,693	83%
Cook	121,682	140,911	164,116	194,852	60%
Kestel	155,908	162,849	183,877	238,157	53%
Groppe	107,572	115,919	180,347	203,651	89%
Riley	119,914	120,392	176,108	203,117	69%
Pace	145,647	167,805	198,712	308,053	112%
Kongstvedt			168,674	268,211	
Edelstein				231,239	

* Figures represent Total Compensation.

At the same time that these executives' salaries and bonuses were increasing, BCBSNCA subscribers' premium rates were also on the rise. For example, from 1988 to 1991, the premium rates for non-group subscribers, as a family, rose from $194.06 to $410.90 per month, or 112 percent.

In 1991, the National Blue Cross and Blue Shield Association conducted an executive compensation survey of its member plans. When comparing Mr. Gamble's compensation to the officers of other plans, we found his salary to be greater than 80 percent of the CEOs of the 60 BCBS Plans that responded to the survey. Thus, using the National Association's data, Mr. Gamble's total compensation ranked in the top 20 percent of all plans even though BCBSNCA, with only 1.1 million subscribers, is of average size.

The Staff notes that senior officers received significant additional benefits. These include, bonuses and up to $13,700 to be spent on any of the following approved items: supplemental life insurance; financial planning services; tax preparation services; medical expense reimbursements; club membership; car allowance; and deferred compensation. Other officers may spend up to $11,000 on a selection of those same items just described.

Additionally, excess benefit agreements were entered into with select senior officers for supplemental pension benefits payable upon retirement or death. Messrs Cook, Gamble, Giuliani, Kestel, Pace and Poffenberger were awarded these benefits. For example, Mr. Gamble will receive approximately $25,000 per month for life, with his wife receiving 50 percent of this upon his death for the remainder of her life.

An additional benefit that the Subcommittee Staff found were ten memberships at the City Club, an exclusive Washington business club, that are maintained by GHMSI. These accounts, according to GHMSI are assigned to Messrs. Giuliani, Brown, Ecker, Groppe, Kahl, Pace, Kongstvedt, Long, Morris and Ward. The Staff also learned that in the past GHMSI has paid for partial initiation fees and membership fees for membership in other business and/or country clubs.

B. *Travel*

The Staff's review of GHMSI travel documents, provided to the Subcommittee by GHMSI, identified abundant evidence of questionable domestic and international travel on behalf of the GHMSI's top executives, members of the Board of Trustees and a number of the GHMSI employees.

While business travel can certainly be a legitimate cost of doing business, the Staff is concerned with the propriety and corporate purpose served by the regular use of First Class or Supersonic air transportation by some of the executives of this not-for-profit entity. In addition, the Staff questions whether deluxe accommodations both here and abroad at some of the world's finest resorts, along with seemingly unrestricted dining and entertainment costs are appropriate, especially for a Plan whose sole purpose for existence is to provide low cost health care coverage to the citizens of the Washington, D.C., Metropolitan area. Such extravagance resulted in millions of dollars of additional expenses to the Plan. The Staff questions whether these funds could not have been better spent on lowering premiums or paying additional claims for the subscribers.

The Staff has reviewed thousands of travel documents in the short time it has conducted its investigation. That review highlights several different types of abuses indicative of the standard operating practices of this Plan. The Staff has segregated these abuses into two broad categories—Executive Travel and Marketing Incentive Trips.

(1) *Executive Travel*

As previously stated, the Staff recognizes the need for both domestic and international travel for a corporation that has numerous international subsidiaries. However, upon review, a pattern soon developed that raised obvious questions concerning how certain people were traveling, dining and sleeping; the purpose of their travel; the amount of work that they conducted; as well as the overall volume of travel they charged to the Plan.

In 6 years, three of the Plan's executives—Messrs. Gamble, Groppe, and Kestel—were able to establish themselves as international globetrotters by together billing GHMSI or its subsidiaries a total of over $1 million for their excursions. Some, if not most, of these trips included 1st class or Supersonic air transportation and deluxe lodging with seemingly unrestricted food and beverage expenditures.

Mr. Gamble had both the most extensive and expensive travel log of any of the reimbursement records reviewed, though excesses were not limited to him alone. According to Mr. Gamble's date book and Travel Expense Reports, he traveled extensively for the years 1988 to 1991. In 1991, the year in which Gamble's travel began to decline, records indicate that he was away from the home office either on business travel or leave for 160 days, or 44 percent of the year. In 1990, Gamble had his most extensive travel year in which he was away 202 days of the year, or 55 percent of the time. In 1989 and 1988, he was away from the office for 173 and 193 days, respectively. The total cost of Mr. Gamble's travel to the Plan from 1987 through July of 1992 was a staggering $447,007.

The sheer amount of this travel raises some concerns about its necessity, as well as the wisdom of the Plan's CEO being away from his home office for such extended periods of time. Some of his most expensive trips beyond the Metropolitan D.C. area included:

—A $28,839 trip to Hong Kong, Singapore and Sydney by Gamble for an International Federation of Voluntary Health Service Funds (IFVHSF) Conference in 1990. The trip lasted 21 days. According to records, Mrs. Gamble also went with her husband on this trip, costing GHMSI $8,235. The Gamble's flew first class to their destination.

—A $25,723 trip to China, Japan, Hong Kong, Hawaii, Singapore and London in 1988 that lasted for 23 days. The purpose of this trip was listed as a meeting with the Peoples Insurance Company of China. Mrs. Gamble again escorted her husband on this trip. They traveled first class.

—A two-day trip to Paris in 1991 aboard the Concorde. This trip cost $6,567, the majority of which was airfare. Coach airfare for the same flight would have been $2,211.

—A two-day trip to Dublin, Ireland, in 1989 which cost $7,909.

—A $7,903 trip to London, Paris, and Zimbabwe in early 1989. The purpose of this meeting was listed as "Meetings and Regional Conference of the International Federation of Voluntary Health Service Funds (IFVHSF)." The entire cost of Gamble's trip was billed to BCBSNCA with no indication of reimbursement by IFVHSF. Additionally, Gamble's Travel Expense Report indicates that all lines of business were charged for this trip. This means that each line of business that is operated within BCBSNCA was affected by this trip, including those lines of business that involve Federal government contracts. According to BCBSNCA records, Mr. Gamble attended this conference to give a speech on fraud in the insurance industry. (Records pertaining to this trip are attached as Appendix G.)

Gamble not only flew first class as a routine matter, he also frequently flew the Concorde to Europe. According to the Subcommittee's review of records, he did so at least 22 times. Based on an estimate of Concorde travel costs by a travel agency utilized by the Senate for official travel, Mr. Gamble's Concorde expenses would have been at least $66,000 (22 x $3000). The average cost of a roundtrip ticket to London on the Concorde today is more than $7400 according to this same source. To understand the excessive nature of such travel, the Staff provides a cost comparison of various modes of travel to London:

Concorde $7,400
First class $3,229
Business class $1,969
Coach $1,222 (depending on the season, this fare may drop as low as $616)

Mr. Gamble is not alone in his use of the Supersonic Concorde. The Staff's review of the Plan's travel records indicate that Mr. Kestel, Mr. Giuliani and Mr. Groppe also did so. In an interview of Dr. Charles Duvall, former Chairman of the Board of Trustees of GHMSI, he told the Staff that he had not been aware of Gamble's frequent use of the Concorde and if he had, "There would have been a problem." Duvall was also unaware of its use by other GHMSI executives.

The Subcommittee found abundant examples of hotel or lodging costs that appear to be unreasonable on their face. Examples of this include Gamble's stay at the Grand Barbados Beach Resort in October, 1990 for $450 per night. In 1992 at the same resort, Gamble requested the Jr. Suite which over-looked the water. This cost the Plan an $452 a night. He stayed at the Imperial Hotel in Tokyo for $330 a night in 1991 and later in that same trip spent $250 a night in Singapore's Shangri-La Hotel. In 1992, Mr. Kestel spent $635 a night in Tucson, Arizona at the Loews Ventana Canyon Resort.

The Staff also uncovered several business trips taken by executives in which golf, dining or other leisure activities appear to have constituted a larger portion of the trip than business activities. These entertainment and leisure activities such as tours and golf, were often paid for by the Plan. Light work schedules were a matter of routine for these travelers.

—In 1991, Mr. Gamble traveled to Mexico for the First Latin American Partners Conference. In the 4 days Gamble was in Mexico, the schedule included only 9 hours of work. This trip cost the Plan over $1,000.

—In 1991, Gamble visited Paris for 3 days for an International Health Benefits, S.A., meeting. This trip cost the Enterprise more than $7,382 for approximately 8 hours of business meetings and two dinners. No meetings were scheduled for Gamble's last day in Paris. A copy of this schedule is attached as Appendix H.

—In 1991, Mr. Gamble went to Minneapolis, Minnesota, for 2 days. In that time, the only scheduled events were a day of golf, followed by a cocktail party and dinner. This cost the Plan $1,359.

David Kestel was another of GHMSI's frequent travelers with business schedules that appeared at times to have limited business content. For example, he made six trips that he called "Site Inspection" trips. He told the Staff that the corporate justification for these trips was to inspect resorts that were potential sites for future Marketing Incentive Trips. His investigative work took him to Bermuda, Portugal, Switzerland, Florida, and California. The Staff has attached as Appendix I a copy of one of Mr. Kestel's inspection trips, in this case to a resort in Faro, Portugal. His "work" schedule for this site visit consisted of "inspecting" the beaches, golf courses, and restaurants of this resort at a cost of $5,000 to the Plan's subscribers.

According to the Staff review, the following costs were incurred by GHMSI for travel expenses for the appropriate years:

1988 $1,792,338
1989 $1,656,521
1990 $2,851,163
1991 $2,841,899

A chart, outlining Messrs. Gamble, Kestel, and Groppe's travel expenses and schedules for the period of 1987–1922, is attached as Appendix J.

Although the actual amount spent by this Plan on travel raises some concerns, GHMSI's practice of charging the costs of most travel to all lines of business raises additional concerns. As mentioned earlier, this means that each line of business operated within BCBSNCA would be charged a certain percentage of these trips, regardless of whether the trip had anything to do with that particular line of business. The Staff questions the appropriateness of this practice, as we fail to understand why all of BCBSNCA's clients, including the Federal Government, should be charged for portions of expenses which often did not benefit them.

(2) *Marketing Incentive Trips*

The Staff learned of another apparent extravagance, the Marketing Incentive Trip, which the Plan sponsored at great cost to its subscribers. These trips were awarded to various employees of the Plan or subsidiary for superior job performance. It appears that the trips were awarded "for two," so that spouses or guests could attend. These trips were all inclusive, meaning that air fare, meals, lodging, entertainment, tours, etc., were paid for by the Plan.

Portugal, Ireland, and Bermuda were but a few of the locations that were chosen for these incentive awards. Several senior executives and their spouses usually attended the trips, in addition to the numerous employees who were actually awarded the trips for their job performance. The Plan justified sending the senior executives along, at Plan expense, since they would normally give a speech or other presentation to the awardees. Each year for the last 6 years, an award trip occurred. The total cost to the Enterprise was a staggering $1,540,749 for the last 6 years, including over $392,000 being spent in April, 1992, to send 127 people to Monterey, California.

The following is a chart prepared by the Staff that summarizes its analysis of these trips. Included is the location, date, cost and number of participants:

Marketing Incentive Trips

Location	Year	Trip Dates	Trip Cost	No. of participants
Casa De Campo, Dominican Republic	1987	2/17–2/22	$ 85,396	47
Killarney-Dublin, Ireland	1988	5/13–5/19	$177,063	71
Castle Harbour, Bermuda	1989	4/23–4/27	$242,952	104
Naples-Orlando, Florida	1990	3/14–3/18	$302,049	104
Algarve-Estoril Portugal	1991	5/13–5/19	$340,387	111
Monterey, California	1992	4/29–5/03	$392,902	127
Total Trip Costs			$1,540,749	

C. *Corporate Account*

Upon reviewing many of the executives' Travel Expense Reports (TERs), it became apparent that when first-class travel was used, the difference between coach

and first class was charged to a separate account, called the GHMSI Corporate Account. The Staff believes that the creation and usage of this account amounted to a subterfuge by senior management to avoid close scrutiny of the excessive costs that they incurred at subscriber expense. The total amount of expenses charged through this Corporate Account for both BCBSNCA and GHMSI for 1988–1992 is $977,975.40.

The Staff was told that this account also paid for entertainment, gifts, spousal airfare and meals, group events, and registration fees. This special account was not widely used at the Plan, and only the President could approve items charged to this account. The Controller of the Plan told the Staff that he could not recall any expenditures to the Corporate Account ever being rejected or not approved by the President or Board.

The Subcommittee Staff discovered that this account was originally created in 1978 to ensure that the costs of upgraded travel would not be charged to the Federal contract. When asked the source of the funding to pay for these excessive travel costs, the Controller, Mr. Krumenacker, told the Staff that the funds for the Corporate Account came from "reserves and are reflected below the line." However, he could not explain how the use of the Plan's reserves somehow lessened the ultimate subscriber impact.

The only oversight of Messrs. Gamble and Giuliani's prerogative to charge expenses to the Corporate Account was exercised by the Chairman of the Board of Trustees, who, until 1992, was Dr. Duvall. When Dr. Duvall was questioned about his knowledge of the Corporate Account, he described the purpose of the account, as others did, and mentioned that he normally reviewed 6-month summaries of the account. He said that basically he was given a stack of documents which roughly outlined what the costs were for and a total amount. He said that usually Gamble told him, "These costs look good to me, please sign off on them," and he did so. When asked where he understood the money for this account came from, Duvall did not exactly know. He told the Staff that it was his and the Board's understanding that the money in the Corporate Account came from interest earned on investments.

Of particular concern to the Staff is the way the account is reported to regulators. The Subcommittee Staff has learned that GHMSI does not report the GHMSI Corporate Account as an expense in its Quarterly and Annual statements filed with their regulators. Instead, the Staff found a peculiar accounting practice wherein GHMSI listed the expenses paid through the Corporate Account as "Other Income Contra." The Staff could not find any valid reason for such a listing of these expenses. In light of the nature of the expenses, the amounts incurred, and the recipients of its benefits, the Plan's "creative accounting" raises the strong possibility that this was done to somehow hide or mask these amounts. The Staff is aware that the Virginia Insurance Department has recently uncovered this strange accounting practice and is also questioning it. A summary detailing the year-by-year expenses charged to this account is attached as Appendix K.

D. *Artwork Commissioned for Joseph Gamble's Retirement Gift*

The Subcommittee has found that BCBSNCA commissioned a local artist to create a three-dimensional collage as a retirement tribute for Joseph Gamble. This gift was paid by the Plan and ultimately cost its subscribers close to $30,000. Mr. Giuliani approved this extravagance.

The Staff was told by the artist that after being contacted by the Plan in October, 1989, for information regarding such a venture, he made a presentation to a group, led by Mr. Giuliani, at GHMSI headquarters in February of 1991. In October of 1991, GHMSI commissioned him to design a collage that is approximately 31" x 38" x 4" at a budget of $25,000. Delivery date was originally scheduled for December, 1992.

In February of 1992, a letter from the artist's studio indicates an agreement between the parties that a new delivery date of November, 1993, had been set. One month later, that delivery date was again changed, via telephone, to November, 1992. This final delivery date was met, and on November 12, 1992, the artist and his studio director presented the artwork to Mr. Gamble at his retirement party held at Congressional Country Club.

Changes to the collage and the delivery date requested by the Plan created a "rush" condition for the artist, resulting in additional charges for the work. This brought the total cost of the gift to $28,995. This amount was charged to the Plan's Corporate Account at the direction of Ben Giuliani, President, and paid in three installments.

Charles Duvall, former Chairman of the Board of GHMSI, was asked if he or the Board was aware of this extravagant gift for Gamble. His reply was curt:

> I found out about it. I don't know who made the decisions [regarding the gift] or when they were made. It had obviously been in the works for a long time. I can't defend it. I find it excessive. He should've gotten a set of golf clubs.

According to attorneys for the Plan, Gamble's collage, which was totally paid for by the Plan's subscribers, is at his home. This was confirmed by the Staff when they interviewed him 2 weeks ago at his house. At that time, Mr. Gamble complained about his treatment at the hands of current management, since all of the Plan's prior Presidents were given a car as a retirement gift. He was obviously miffed that he did not get his car, although he was grateful for the collage. He jokingly noted that it really didn't matter in the end, since his company car doesn't work that well, and he left it at his other home at Hilton Head, South Carolina.

E. *Hotel and Club Costs*

The Staff reviewed GHMSI and BCBSNCA expenses at a variety of clubs and hotels in the Washington, D.C., area. It has been mentioned earlier that GHMSI, as a fringe benefit to many of its officers, paid the initiation fees and partial dues for membership in area clubs. The Staff discovered that in some cases, this fringe benefit was taken to extremes when golf balls and greens fees became regular charges to the Plan. Additionally, banquets, parties, and seminars have raised the Staff's attention, both for their volume and cost to the Plan's subscribers. For example:

—The Plan hosted two costly holiday parties in 1989 and 1990 at the Hyatt Regency Crystal City. The Staff believes these were Christmas parties. Each of these events was organized for approximately 150 people and featured floral centerpieces; Gulf shrimp, beef tenderloin, veal, and salmon. The bar bills alone totaled over $9,170, with a total expense to the Plan for these two parties in excess of $34,000.

—The Plan spent over $102,500 at the City Club of Washington, a business club in the District, for food and beverage during 1988–1991. The Plan owns 10 corporate memberships at the Club.

—Two of the Plan's officers, David Kestel and Ben Giuliani, had memberships at The Congressional Country Club. The Staff determined that between the two men, at least 10 "party orders" were paid for by the Plan, totaling over $10,000 for conferences, business meetings, or retirement parties. Mr. Giuliani joined the club in 1988, for a fee of $10,000, paid by GHMSI.

From all of the club memberships and club activities that the Staff examined, one individual emerged from the Plan as charging numerous golf fees to the Plan. Because David Kestel, President and CEO of the Insurance Group of BCBSNCA and a BCBSNCA Vice President, continuously appeared in a variety of clubs' records regarding his golf expenditures, the Staff scrutinized some of his costs to the Plan.

From 1988 to 1992, Kestel amassed bills totaling $10,573 exclusively for golf and golf related items and submitted them to the Plan as local business expenses. While the Subcommittee Staff recognizes that a certain amount of business may be conducted in such settings, it wonders if Mr. Kestel actually had an office at BCBSNCA or at a local golf course. Kestel told the Subcommittee Staff that it had been agreed to, long ago, between him, Gamble, and Giuliani that where he conducted business didn't matter, and it could be charged to the Plan. Attached as Appendix L is a detailed account of Kestel's golf charges to the Plan.

The Subcommittee additionally reviewed records from the Tournament Players Club; and found that David Kestel had significant charges there as well, which the Plan paid for. This review showed that he and others amassed thousands of dollars in bills at this exclusive golf club. These bills, totaling approximately $44,029 for December, 1987, to November, 1992, were sent directly to BCBSNCA for payment. Apparently other executives were able to make charges to this membership, as statements from the club indicate certain charges are attributed to S.J. Pace, G.A. Brown, and J.P. Kahl and were charged to a variety of lines of businesses.

Items that were regularly paid for by the Plan included golf balls, range balls, cart rental, guest greens fees, charges to the Players Pub, headgear, golf outings, dining expenses, amusement taxes, locker rental and dues. In one instance, a meeting/luncheon accounted for more than $3,000 in monthly costs. There were also instances in which men's shirts and sweaters were charged to the account.

GHMSI provided the Subcommittee with a list of all of its club memberships. The list is quite voluminous and thus the Staff was only able to review a few of the club memberships and activities, as indicated above. Because of the volume of questionable expenditures that the Staff found in those accounts, it raises the question of potential areas for possible abuse and the extent of potential waste that may have

occurred. The Plan's membership list will be made part of the Subcommittee's hearing record.

F. *GHMSI/Subsidiary Sponsored Events and Charities*

The Subcommittee requested from GHMSI a list of charitable events and groups that were sponsored either by the Parent company or its subsidiaries from 1988–1992. While it is very difficult to criticize the obvious charitable nature of GHMSI and many of the organizations that benefited from its generosity, we question the appropriateness of a non-profit company making charitable contributions at a time when subscriber rates are rising. Additionally, several of the for-profit subsidiaries that were making such contributions, had continuously operated in the red. For example, CapitalCare made contributions reaching $348,000 in 1988, the year in which the HMO took its most serious financial loss. In regard to Protocol, it spent $72,000 in 1991, though it lost approximately $4.7 million that year.

One example of the type of questionable giving that has come to the Subcommittee's attention involves Protocol's sponsorship of The International Gold Cup Races held in The Plains, Virginia. The Gold Cup races are a program of seven horse races sanctioned by the National Steeplechase and Hunt Association. The races are known throughout Virginia as a fashionable event that attracts an upscale clientele that enjoys catered food and horses.

Over a 3-year period, Protocol invested more than $58,000 in this event, reportedly for marketing purposes. According to officials from the Virginia Gold Cup Association, Protocol became involved with the races in the summer of 1990 and later that year signed a contract tying the company to sponsor races for the next 2 years.

Initially in 1990, Protocol contracted for a hospitality tent at the event but later signed a new agreement for a larger tent and to sponsor one of the races. Gold Cup officials said that "apparently the race sponsorship and hospitality was very popular with Protocol's customers and guests" and that the company then entered into a 2 year/$20,000 per year agreement to sponsor a more prestigious race. According to these same officials, sponsorship proceeded normally in 1991.

In July of 1992, shortly after our first hearing, Race Chairman Langhorne Bond received a call from Protocol stating it "had not budgeted" for the 1992 race and would not be able to participate. However, the sponsorship contract had no provision for cancellation, and Mr. Bond thus determined that Protocol was locked into the agreement. Protocol was notified of this by letter.

In October, 1992, Protocol notified the Virginia Gold Cup Association that other firms, USA Healthnet and Association Management, Inc. would assume Protocol's sponsorship and all banners and signs should reflect the new sponsor. During an interview with Hollins Riley, the former President of Protocol, he told the Staff that Ben Giuliani made the decision to "lower Protocol's profile" at the race. Riley, on learning that the contract could not be broken, arranged for USA Healthnet and Association Management to sponsor the race in Protocol's place. Yet, they were not required to reimburse Protocol the $20,000 fee that had already been paid to the Gold Cup officials, essentially giving USA Healthnet and Association Management this as a gift. The Staff also learned that Riley has a financial interest in Association Management and thus was giving himself "a gift" at Protocol's expense. Riley invited prospective clients of Association Management to the tent and without reimbursement to Protocol.

Gold Cup officials said that during conversations with Protocol regarding its wishes to disassociate with the Gold Cup races, it became evident that the company was "concerned about appearances." Gold Cup officials said that the publicity that some Blue Cross and Blue Shield plans were receiving regarding extravagant expenses was very clearly unnerving Protocol personnel and Protocol made it very clear that the "company's name" could not be used in conjunction with the 1992 event.

The expenditure of $58,122 toward these events appears to have served more of a social function rather than any health care related purpose. It also is clear that Protocol and its parent, GHMSI/BCBSNCA, too, became aware of the appearance of such a sponsorship at a time of declining revenues and a Subcommittee investigation. They sought to avoid the public scrutiny by having other sponsors step in, even though Protocol had paid for the sponsorship and could not get its money back. Again, we question the reasonableness of this sort of investment by a company that was not profitable and was proving to be a financial burden to its parent, GHMSI/BCBSNCA.

Attached as Appendix M is a list of GHMSI and its subsidiaries' sponsored events and charitable contributions from 1988 to 1992. During this time, the grand total of the Plan's generosity totaled $1,749,363.

VII. OVERSIGHT BY THE BOARD OF TRUSTEES: A PLIANT BOARD

As reported previously, Congress specifically described the authority of GHMSI's Board:

> . . . The business and affairs of this corporation shall be conducted by its board of trustees, who shall have full power and authority in the premises, including authority to provide for all expenses incident to the conduct and management of its business and affairs. . . .

Subcommittee Staff reviewed Board meeting minutes as well as interviewed former and present members to learn about their understanding of this charge, and their thoughts about the way business was conducted while Joe Gamble, a fellow trustee, was CEO. Subcommittee Staff found that generally the Board took a very broad policy approach to its mission and did not get involved with any of the details, including financial details, of the Corporation's business dealings.

The Staff believes that the Board was negligent in its duties and was co-opted by the management it was charged to control. Rather than delve into the hard-core financial issues related to the creation of GHMSI's various subsidiaries, the Board accepted management's projections and approved of its practices. Although perhaps well-intentioned, the Board members never took their jobs seriously—until it was too late. Subcommittee Staff found from a review of the Board minutes that it was only upon learning that they could possibly be liable for potential negligence that Board members became concerned enough in 1992 to hire an outside consultant to advise them, and in July, 1992, voted to increase their Director's and officer's liability coverage. In some Board meetings, discussion of potential liability appeared to have been the most important topic of discussion, rather than Plan operations. It was not until October 20, 1992, that outside attorneys briefed the Board on their duties and responsibilities.

The story of the Board and Joe Gamble's manipulation of the it begins with the creation of GHMSI. Before the merger of GHI (Blue Cross) with MSDC (Blue Shield), Mr. Gamble was the President of GHI and Victor Brian was the President of MSDC. At that time there were a total of eight physicians on the Blue Shield Board, and there was a requirement that half of the Board of Blue Shield consist of physicians. Each physician on the Blue Shield Board had the dual role of representing the views of both physicians and patients. When the idea of a merger between GHI and MSDC was presented to Blue Shield board members, they were wary that a merger would allow Blue Cross to swallow up Blue Shield. However, after Mr. Brian had provided assurance that it would be financially beneficial for the two to merge and that he would be in charge of the new Board, Blue Shield board members agreed.

As a result of the union between Blue Cross and Blue Shield in 1985, the newly formed entity, GHMSI, had a total of 36 trustees, less than half of whom were physicians.

The physicians from both Boards decided that since the new CEO, Joe Gamble, was not a physician, the new Chairman of the Board should be a physician. In July 1986, when Dr. Jack Kleh retired as Chairman, he suggested that Dr. Charles Duvall, a member of the GHI Board since 1982, become the new Chairman. Dr. Duvall remained Chairman of GHMSI from 1986 until the fall of 1992, when he stepped down to devote more time to his practice and Peter O'Malley took over. Duvall commented to the Staff that it cost him $1,500 to $2,000 in lost patient time on the days he devoted to GHMSI.

According to former Board members and Gamble himself, Gamble wanted to run "an empire." His ideas included taking the BCBS logo worldwide, regionalizing the Mid-Atlantic plans, (commonly referred to as "Big Mac," the idea consisted of merging BCBSNCA with Plans in Maryland, Virginia, and Delaware) and eventually taking control from the President of the National Association. He began creating subsidiaries, as well as making attempts to affiliate with other Plans. Gamble also talked about taking over the Arizona and Utah Plans and fought hard in the attempt to merge with West Virginia. Gamble made it known that he wished to be Chairman of the GHMSI Board, and that he also envisioned OPM contracting with his Plan, and not through the National Association for the FEP business. The Board became enamored with their President and his vast visions for their Blue Cross and Blue Shield Plan.

In January, 1985, the Board, at Gamble's suggestion, voted to compensate itself. Only two Board members refused the stipend. According to one former Board member, who refused payment, it was wrong for a non-profit corporation to pay its Board, because the Board then "gets too close" to management. According to this

same trustee, once the other trustees received money from Gamble, they stopped acting as individuals and became Gamble's "yes men." Although there were bankers and lawyers on the GHMSI Board, no one asked for documentation to support Gamble's business ideas. Gamble's requests were "rubberstamped." See Appendix N for a list of payments to GHMSI Board members.

In fact, on March 8, 1988, the Board of Trustees accepted the following recommendations from its own Long-Range Planning Committee:

> That it be BCBSNCA's policy to encourage expansion and diversification, both domestically and internationally, in those businesses that are incidental to or supportive of the purpose, business and affairs of this Corporation or its subsidiaries and affiliates as to minimize the negative effect on the Corporation during business cycles when underwriting losses can be expected to occur.

Our investigation found that from January 1, 1988, through December 1, 1992, the Corporation formed or acquired controlling interests directly or indirectly in 28 subsidiaries. Evidence indicates Mr. Gamble and senior management entered into these acquisitions subject to the approval of the Board of Trustees. However, in the course of approving the acquisitions, it does not appear from the Board minutes or interviews with former Board members that the Board of Trustees adequately considered the funding necessary to reach a break-even point or to obtain profitability. The Board also failed to assure management established adequate internal controls to monitor and administer subsidiaries; obtained credible actuarial data necessary to establish adequate premiums prior to conducting business in foreign countries; or employed persons with the proper expertise in the Corporation to enter into certain ventures, such as reinsurance. As a matter of fact, the Corporation's reinsurance agreements were not even subject to Board approval.

The Corporation's overall strategy was to form subsidiaries in order to insulate itself from the down cycles inherent in the health insurance industry. This strategy has failed and has dangerously depleted the Corporation's financial reserves. Moreover, it does not appear that the Board of trustees was vigilant in moving to stop the depletion of the Corporation's total reserves and unassigned funds resulting from subsidiary losses.

According to former Board members, it was only the physicians on the Board who offered resistance to Gamble's ideas. However, due to a law passed by the Maryland legislature GHMSI decided to reduce the Board from 20 to 16 members in January, 1989, with only four being health care providers. At this point, one trustee, who had also refused to receive payment, resigned from the Board. He told Subcommittee Staff that his feeling was that only the old Blue Cross Board members and Gamble's "favorite physicians" would be left and that the Blue Shield position would be completely outnumbered. He told Subcommittee Staff that "because he did not agree with Gamble's decisions, he was of no use to the GHMSI Board." In fact, it was GHMSI's officers that selected new Board members when vacancies occurred on the Board.

Subcommittee Staff were told that it was clear that Gamble preferred that the Board take a "hands off" approach and be involved only with broad policy making decisions, rather than detailed analysis of the issues.

The Staff is concerned about these findings because the GHMSI Board of Trustees is responsible for managing the property, business, and affairs of the Corporation. Board meetings, which were typically held every 2 months, began at 6 p.m. with cocktails, with dinner served at 7 p.m. After the trustees finished dining, the actual meetings would begin at around 8 p.m. and usually end at around 10 p.m. During the Board meetings, the Financial Report was given very quickly and without substantial discussion. Former Board members told the Staff that most times Gamble had already created a subsidiary or was well on his way to purchasing a plan before the Board was aware or could protest.

Charles Duvall, the former Chairman of the Board, told the Subcommittee Staff that when the subsidiary activity was presented, it usually focused on the "big picture" rather than the finances involved. Gamble's style was to brief the Board on an idea and then tell the Board that they had to vote on it that same night. One former member complained that the Board never had any time to think things over. For example, although the former Chairman of the Board told the Staff that he saw documentation related to the affiliation with Blue Cross of Jamaica (BCJ), other former trustees told the Subcommittee that there were no figures or documentation presented in connection with BCJ. One former member remarked that all he remembers is Gamble saying that "the possibilities (in Jamaica) are endless."

Duvall described a similar situation where Gamble would call him before one of the board meetings and ask him to show up a few minutes early to go over the corporate account. (This account was used for miscellaneous expenses that were not to be a part of the actuarial determination of premiums.) Gamble would then present him with a one inch thick stack of summaries that included monthly break-outs by general category. The former Chairman of the Board said that he never saw any supporting documentation, but would just review the summary and initial it.

In other situations, Gamble apparently misled the Board. For instance, Gamble always assured the Board that the subsidiary costs were not being charged to BCBS reserves, even though the loans to the subsidiaries were being guaranteed by the Plan. One former Board member said that Gamble told the Board that GHMSI was not paying interest on the lines of credit it was extending to its subsidiaries; that it was only securing the loans with the bank. The Board later determined that this was not true once the subsidiaries were unable to make the payments. Another example of misleading information was when Gamble told the Board that the Plan withdrew from the Medicare Part A contract because it was "not profitable" for them, when in fact, the Plan had tried very hard to keep the contract with the Federal Government but was removed for poor performance.

It was Gamble's policy to attend and contribute to Board and Committee meetings, including those discussions that centered around his own compensation. In fact, the former Chairman of the Board told us that when the Audit Committee met alone in March, 1992, Gamble took formal exception to the meeting, and it became a divisive point as confirmed in recent Staff interviews of Gamble.

The former Chairman of the Board told the Subcommittee Staff that the only compensation which the Board received was Gamble's, unless the other officers' salary ceilings began to hit Gamble's floor, which happened in 1989 when Gamble proposed a raise for Giuliani that would have made his overall compensation higher than Gamble's. According to other Board members, they did not actually know Gamble's total compensation, but instead, voted on a percentage increase each year in June. The percentage increase was suggested by the Finance Committee to the full Board for a vote.

Gamble's compensation increases were based on the results of studies down by outside consultants on comparable salaries in the D.C. area. Interestingly enough, the compensation consultants were hired by and reported these results to Gamble. Only then did they report to the Compensation Committee. Former Board members told the Subcommittee that Gamble used to say that compensation didn't matter to him, but that many of the officers could receive more elsewhere and the Plan would lose their expertise if they didn't receive increases. Invariably, the full Board approved the suggested percentage increases each year for Gamble and his management team.

Board members were treated to retreats at the Greenbrier, the Homestead, and the Williamsburg Inn on a routine basis, with all expenses paid, including free bar and golf. Spouses were also invited. The retreats would begin on a Friday and end on a Sunday. Business meetings were held after breakfast at around 8 or 9 a.m. until noon. Afternoons were spent golfing and attending other leisure activities. Subcommittee Staff were told that these annual meetings were the most useful of all because it was the only time that there was any detailed discussions about the subsidiaries.

The former Chairman of the Board told the Staff that, although he had some concerns about GHMSI's trademark fight with the National Association, the attempted alliance with the West Virginia Plan, and GHMSI's affiliation with BCJ, none of these issues bothered him enough that he questioned Gamble's leadership. He added that for a long time GHMSI's focus was on growth and revenue, while immediate profitability was set aside with profits always promised for the future. It was always the Board's hope that there would be a turnaround, encouraged by Gambles' continuous optimistic forecasts.

Charles Duvall, the former Chairman of the Board, told the Staff that he did not become alarmed about the state of GHMSI's financial affairs until February, 1992, when another trustee presented the Board with a spreadsheet that showed that GHMSI was losing money and projections were looking grossly different from what the Board expected. According to Duvall, as a result of this spreadsheet, the Chairman and other members became concerned about their own liability. (At one point their liability insurance was increased from $15 million to $20 million.)

In addition, the former Chairman told the Subcommittee Staff that GHMSI's own legal counsel had sent over a 42-page legal brief which included information on D&O Insurance that essentially told the Board that if a Trustee does not have enough information to make a decision and does not "go after" that information,

then he is exposed to potential civil liabilities. Because the Board felt that they "were exposed," the former Chairman decided to hire an outside consultant, McKinsey and Company, which would report directly to him about the state of the Plan. The Chairman told the Subcommittee Staff that, although he felt differently at the time, in retrospect he realizes the Board did not have enough information to act responsibly. He also told the Subcommittee Staff that Gamble adamantly opposed the McKinsey study and that this was the first time a consultant was hired that did not report directly to Gamble but, rather, reported to the Board.

Staff interviewed representatives from McKinsey who have stated that they reported the following to Mr. Duvall and the Board of Trustees in the fall of 1992:

—GHMSI did not have the capital to fund its diversification efforts "in a first-class way";

—GHMSI subsidiaries had moved too far from the core business;

—GHMSI did not know the marketplace;

—GHMSI did not have the skills to move away from the core business; and

—after reviewing GHMSI profit/loss statements, McKinsey recommended that over half of its subsidiaries be sold or otherwise disposed of.

The former Chairman of the Board also complained that Gamble had "railroaded" him when he attended what he referred to as a "preorchestrated" meeting regarding a deal to sell the subsidiary Health Management Strategies (HMS). Part of the deal to sell HMS included what he called a "golden parachute" for the President, Ms. Seton Shields. Shields was offered: (1) a cash payment if she fostered a successful sale of the corporation, and (2) Shields was given the option to work for the new owner, or if she were let go, the option to work for GHMSI at a similar job with the same salary. Should she not enjoy her new job at GHMSI, she had the option to leave with 2 full years of salary. The Board approved the deal. The former Chairman of the Board said that the meeting was done in the usual "rush" fashion, where he had to make a decision right away without time to think things over, and that he felt "used" by Gamble.

The Chairman of the Board also told Subcommittee Staff that he did not become aware that the Plan was being monitored by the National Association until Giuliani informed him in the spring of 1992. In fact, he was surprised when Staff informed him that the National Association had been monitoring the Plan since 1988. It appears that the National Association had, also, never informed the Board of this fact until the fall of 1992.

The Subcommittee Staff believe that the Board may have been negligent in their duties by passively relinquishing their responsibilities to Mr. Gamble and his management team. It appears that not until they learned that their negligence may result in civil liability did they hire outside consultants and begin to reassess the management decisions of the prior years which the Board had previously approved.

VIII. OVERSIGHT BY THE NATIONAL ASSOCIATION

A review of the dealings between the National Blue Cross and Blue Shield Association (National Association) and GHMSI from 1986 through mid-1992 raises a number of questions about the oversight of the National Association and its ability to enforce its membership standards. The National Association is equivalent to a trade association, keenly interested in and responsible for protecting its Blue Cross and Blue Shield trademarks. It has, and attempts to enforce, membership standards to ensure that its member Plans operate within the stated guidelines and are financially sound. After carefully reviewing the record of the National Association's dealings with GHMSI and from numerous interviews, the Staff has a number of observations about that role. They include:

—The Association's minimum financial standard for its member Plans is insufficient;

—The Association has difficulty in adequately enforcing its internal standards;

—The Association can apparently be prevented from obtaining adequate financial information to effectively monitor a Plan if it is involved in a lawsuit with that Plan;

—The Association appears to be uninterested in Plan subsidiaries that are unrelated to the core business unless they cause severe financial strain to the Plan;

—The Association failed to determine the financial condition of GHMSI's subsidiaries and the resultant financial impact on the parent Plan;

—The Association may be incapable of financially assisting its member Plans when they run into financial trouble, and;

—The Association has historically failed to share information with regulators and the independent Boards of their Plans.

A. *Background*

GHMSI is a regular member of the Blue Cross and Blue Shield Association, a non-profit Illinois based corporation which acts as a coordinating agency for its 72 Member Plans. The National Association has a number of self-declared functions, including promoting public acceptance of the principle of prepaid health services, initiating and coordinating programs of public education and professional relations, administering the service mark and trade name license agreements, and providing research, statistical, actuarial, marketing, and other services to the Plans. The National Association also exerts influence on the quality and availability of health services by control over the Blue Cross and Blue Shield trade marks. It has eight standards that must be adhered to before a plan can use the trademarks. The National Association has also developed a system for monitoring its member plans to ensure adherence to its internal Standards.

Part of this monitoring is conducted by requiring Plans to furnish the Association with Quarterly Financial Reports, Quarterly Financial Forecasts, Annual Certified Audit Reports, Insurance Department Examination Reports, Annual Statements filed with State Insurance Departments (with actuarial certifying statements), and Consolidating Reports.

B. *History of the Relationship between the Association and GHMSI*

Staff from the Association's Business Performance Review office (BPR), which is responsible for plan monitoring told Subcommittee Staff that before the merger of Group Hospital Inc. (GHI) and Medical Services for the District of Columbia (MSDC), both plans had a history of cooperating with the National Association. However, after the 1985 merger occurred, the National Association Staff said that three words best characterize GHMSI and its attitude toward the National Association "uncooperative, difficult, and non-disclosure."

Subcommittee Staff learned that by 1988, the National Association was concerned about GHMSI's financial condition and decided to renew its membership on a conditional basis. Association records show that this was specifically due to the Plan's low reserve position of 1.12 months and low liquidity of 1.01 months for year ending December 31, 1987. By 1990, the Plan's reserve and liquidity position had fallen even further, with reserve at 0.73 months and liquidity at 0.46 months for year ending December 31, 1989. As a result, the National Association required that the Plan, in addition to submitting the regularly required reports, also begin submitting monthly financial reports.

The National Association continued to renew the Plan's membership on a conditional basis until 1991, when they revised the system used to monitor member Plans. Under the new monitoring system, GHMSI was granted full membership status, but placed on the Association's "monitoring list" at the "concern" stage, due to the Plan's continued failure to meet membership standards relating to financial responsibility. The 1991 decision was based on the fact that the Plan had reported reserves of 0.73 months and liquidity of 0.55 months for year ending December 31, 1990. To make matters worse, subsequent analysis by the National Association showed that due to $42 million in pledged investments, the Plan's actual reserve was 0.22 months and liquidity was 0.18 months for year ending December 31, 1990.

The National Association continued to monitor the Plan at the "concern stage" through the fall of 1992. At 12/31/91 the Plan's reserve was 0.26 months and liquidity was 0.17 months. This has further declined so that by June 30, 1992, reserves were at 0.11 months and liquidity at 0.08 months.

National Association employees told the Staff that monitoring the DC Plan was especially difficult due to the unwillingness of GHMSI's management to provide them with complete information. The Plan, during its protracted dispute over the international use of the names and marks with the National Association, refused to provide information on the Plan's various subsidiaries and their financial drain on the Plan.

The National Association staff explained that after they filed a lawsuit against GHMSI in 1989, GHMSI claimed that due to antitrust concerns, it was not obligated to supply financial information to the Association on its subsidiaries. An Association employee told the Staff that during the litigation,

> . . . We were not allowed to pursue information on GHMSI's subsidiaries until the Court had made a final decision in the case.

In 1990 the Court ruled in the Association's favor, but GHMSI appealed. In 1991 the Association won the appeal.

Ironically, Association officials told the Staff that during the dispute over the names and marks, Joe Gamble, the President of the Plan remained actively involved on the Association's trade mark enforcement committee, ensuring other Plans did not violate the trademark rules.

With the dispute behind them, the National Association began pursuing information on GHMSI's financial status. The National Association maintained to the Staff that it was during the 1991 annual review process that the Association was "shocked" to finally learn the extent to which GHMSI had been damaged. According to the National Association, the audited financial statements submitted to the Association for the year ending December 31, 1990, were those of BCBSNCA as opposed to the GHMSI consolidated statements and were misleading because according to the National Association, it did not reflect the true financial picture.

However, the Staff notes that Price Waterhouse had qualified its opinion on the BCBSNCA audit report and noted therein that, had proper accounting procedures been followed, BCBSNCA's reserves would be $24.4 million, not the $82.6 million as the Plan had reported. The Staff further notes that Price Waterhouse had made like disclosure in BCBSNCA's audit for 1989 and 1988.

When questioned by the Subcommittee Staff about the thoroughness and effort that the Association made to gain access to the Plan's financial and subsidiary data, Association officials replied that the Association trusts its member Plans to submit accurate data. Association officials also revealed to the Subcommittee Staff that subsidiaries are important only if they adversely affect the financial status of a Plan. Otherwise, the Association does not concern itself with subsidiaries created by its member Plans.

Upon discovering that GHMSI had been "misleading" them for years, the Association demanded in November 1991 that the Plan start reporting data correctly. However, according to the Association, they still continued to receive resistance from the Plan, even into the first half of 1992. The Association explained that the Plan submitted incomplete information, repeatedly requested extensions for submitting information, and postponed on-site visits by the Association. According to an Association representative, it is their impression that Mr. Gamble was the main source behind the resistance, and that Ben Giuliani carried out his orders, if at times, reluctantly. The Staff was told that, on more than one occasion, Giuliani had confided that he ". . . is only in charge of the BCBSNCA Division and has no control over other GHMSI activities."

The Staff notes that even in the face of the Plan's obstructionist behavior, the National Association was either unwilling or unable to force more thorough compliance. It appears the Association has little enforcement capability, short of moving to revoke the trademarks of a Plan—the ultimate weapon. The National Association is limited to only one punishment for violating its license agreement; and, since it would mean "pulling the license" of a Plan, it can never be practically used by the Association, without causing major disruption to thousands of people and tarnishing its well-polished public image.

In January, 1992, the Association developed a "specific monitoring program" for GHMSI, which was more intensive than the normal monitoring process and included on-site visits. However, GHMSI management still refused to allow Association staff to actually meet with its subsidiaries' officers. One National Association employee candidly described the subsidiary data available at the Plan as nothing more than "what they thought everyone wanted to see," adding that "none of the forecasts could be substantiated." But, again, as the Staff has noted, there does not appear to have been any effective way for the Association to force the Plan to provide full disclosure.

In April, 1992, the Virginia Insurance Bureau initiated an on-site examination of the Plan for the years 1988 through 1991. Yet, even though the Plan was being reviewed by the Virginia regulators, as well as its own Association, it still purchased another subsidiary, First Continental Life and Accident Insurance Company in April 1992.

According to a National Association representative, by May 1992 there was a sense of urgency about the Plan because of the Virginia Insurance Bureau's review. Further, it was not until July, 1992, that the Plan began disclosing more detailed and accurate information to the Association.

The National Association attributes this disclosure to the fact that Mr. Giuliani took control of daily operations in July. However, the Subcommittee Staff is struck by the fact that this change in attitude toward disclosure coincided with the Subcommittee's first hearings on the Blue Cross and Blue Shield program and public

testimony from regulators that was critical of the DC Plan and the National Association's monitoring practices.

At the end of July, Giuliani promised the Association that a new recovery plan would be developed. However, only 1 week later the Virginia Insurance Bureau issued a consent order requiring that the Plan acquire prior written approval for transactions with affiliates, not conduct transactions with officers and directors, file an investment plan, and file a plan to sell or liquidate its real estate portfolio.

By the time Mr. Giuliani met with the Association in September 1992 to present a timeframe for a new recovery plan, the Association was already aware that the Virginia Insurance Bureau was proposing significant adjustments which would reduce GHMSI's reserves. Since the Association feared that the Plan might not reach Virginia's 45 day reserve requirement, in early October, the Association began its licensure termination process, giving the Plan until November 7, 1992, to enter into an acceptable business arrangement that would allow the Plan to remain viable. The Staff was told that the Association feared that if the Virginia Insurance Commissioner stopped the Plan's operations in Virginia, the names and marks held by GHMSI could possibly end up under the control of a potential receiver and/or court if GHMSI became impaired as a result of Virginia's action. Thus, the National Association was concerned that it move first, before the regulator, to protect its control over the trademarks.

As part of the termination process, on October 5, 1992, Association representatives, including Mr. Bernard Tresnowski, the President of the National Association, met with GHMSI's Executive Committee and informed them that "unless GHMSI adopts a 'cure process,' a notice will be sent to member Plans on November 7, 1992, calling a special meeting of Plans on November 18-19 to vote on the question of terminating GHMSI's License Agreement and membership in BCBSA."

According to the Chairman of the GHMSI's Board, Mr. Peter O'Malley:

> The National Association is acting under pressure of the regulatory environment we are in and wants to be in a position of moving against GHMSI, if required, before the Virginia Commissioner does.

He said BCBSA's representative characterized GHMSI's reserves as "suspect," and its liquidity as "the worst in the system." Around the same time, Mr. Tresnowski had also telephoned board member and former Chairman, Dr. Charles Duvall, to ask that GHMSI seriously consider an affiliation with BCBS of Virginia.

At a Special Meeting of the GHMSI Board of Trustees, held on October 26, 1992, Mr. Tresnowski again met with the Board and further clarified that it is the National Association's duty to protect the names and marks, and that:

> It is important to the Association that there not be another Plan, such as Blue Cross Blue Shield West Virginia, that must be liquidated due to insolvency.

He further went on to say that the Association had been concerned about GHMSI for some time, and that its concerns were heightened during 1991 by a perception that financial data received from GHMSI ". . . was not totally accurate." He added that the Association was also concerned that there was no acceptable recovery program.

The Board's minutes reflect that, in response to questions from board members regarding the National Asssociation's capacity to loan funds to a Plan:

> "Mr. Tresnowski explained that the National Association had 'passed the hat' during a financial need of the Buffalo Plan and was turned down by member Plans, even though there was security which could be pledged. In addition, he said BCBSA simply does not have the necessary funding to assist Plans with insolvency type needs."

The National Association told the Staff that they had stopped its termination process from continuing forward because by the end of October an agreement to consider an affiliation had been signed between GHMSI and Blue Cross Blue Shield Virginia. However, the Association also made it clear to Staff that if the Virginia Commissioner makes a move to stop the Plan's operations in Virginia, the Association will have to pull the names and marks.

In November, 1992, Virginia Insurance Commissioner Foster, informed the Plan that, under the 45 day requirement, they must receive a $15 million surplus infusion and reinsure the Virginia based business in order to continue operating in Virginia. Association officials told Staff that in order to protect the subscribers and because "the Association cannot allow another West Virginia," the Board of the National Association provided GHMSI with the $15 million surplus infusion, funds the

Association obtained by accelerating the payment of the 1993 dues of its 71 other member Plans. The $15 million infusion is a loan which is due February 18, 1993. If it is not paid back on time, GHMSI will have to voluntarily return its license to the National Association. As part of this infusion, the Virginia-based business was reinsured, effective December 1, 1992, through an agreement with BCS Financial Corporation, a company affiliated with the National Association and owned by a number of member Plans.

The Staff notes that a representative of the National Association's monitoring team told Staff that she did not understand the full extent of GHMSI's subsidiary activity, including its foreign reinsurance business, until December, 1992. And, from the surprise on their faces during an interview with Staff, it seems that the National Association is still learning.

The Staff has learned that the financial shape of the Association, itself, may limit its ability to assist member Plans. A recent article in *Modern Healthcare* states that the $15 million surplus note provided to GHMSI equals the Association's entire equity as of September 30, 1992. The article, which cites the National Association's annual financial report, also notes that the $15 million surplus note is the second such effort this year by the Association. Apparently, it bought a $10 million surplus note issued by Buffalo-based Blue Cross of Western New York, which is involved in a merger with Blue Shield of Western New York, also of Buffalo. As a result, the Association is actually projected to show a loss of $1 million for 1992, according to the article.

IX. OVERSIGHT BY THE STATE REGULATOR

As previously explained, GHMSI was exempt from regulation by the District of Columbia, its place of domicile, until legislation passed in September, 1992, changing its Congressional charter. The Staff has been informed that the District of Columbia is moving quickly to draft appropriate regulations to oversee the operations of GHMSI.

As a result, GHMSI has in the past been examined and partially overseen by a patchwork of State regulation that inherently could not adequately oversee its operations. Because GHMSI is licensed in Maryland and Virginia, those regulators have applied their rules to the DC Plan for that portion of the Plan's business sold within their respective States. This situation is unique in the regulation of the insurance industry. Normally, regulators rely on the regulator of a company's "State of domicile" to conduct primary oversight and control over an insurance carrier and, through its ultimate authority, to rescind its license or place the Plan into receivership or rehabilitation. Of course, such was not the case with GHMSI, since D.C. lacked such authority.

On July 2, 1992, the Subcommittee held its first hearing on its ongoing investigation of the Blue Cross and Blue Shield system, during which Mr. Robert M. Willis, the Superintendent of Insurance for the District of Columbia, testified. He explained that difficulty presented by this patchwork that placed GHMSI beyond the scope of most of his authority:

> Mr. WILLIS. . . . If we can imagine that a raft is floating down a river and on the shoreline stands the Commissioner . . . from the State of Maryland, who has a gaff hook and has the ability to snag the raft before it goes over Niagara Falls. That is the nexus that he has through licensing the Blues relative to the Maryland situation.
>
> The District of Columbia is situated beyond the edge of the fall, in fact, at the bottom of the fall, and can only report the result of the raft having gone over the falls. That is the restriction of the charter. By law, I have the statutory duty to tell the Corporation Counsel that I believe that GHMSI—and I am not saying that is the case, but were that the case—has reached the point where the financial condition of the company is impaired. So I am simply in a role of having to report what has happened, that an insolvency has, in fact, occurred, and now we need to take some legal action to remedy what is left, to put the pieces together, perhaps.

The Staff has found that GHMSI apparently became quite adept at playing the three jurisdictions off each other. Steven Foster, the Virginia Insurance Commissioner told the Staff that he has never experienced the level of difficulty in regulating an insurance company that he historically had with GHMSI. Commissioner Foster told the Staff that he has only had five "screaming matches" with industry officials in his career. All five occurred in verbal exchanges between himself and senior officers of GHMSI. In a July, 1992 interview, Foster told the Staff that he felt

GHMSI's representatives had consistently misrepresented GHMSI's financial and business activities to him.

Likewise, in an interview with Maryland's former Acting Insurance Commissioner, Martha Roach, the Staff was told that she also faced continual problems with GHMSI, the most serious being they would never tell her the full truth about their activities in her State. Matters became so serious that she had to issue an order requiring GHMSI and her own Maryland Plan to cease subscribing operations in Maryland unless they obtained written prior approval from her office.

Former Superintendent of Insurance for the District of Columbia, Margarette Stokes, had similar problems with GHMSI. Even though the Plan was not regulated by her office, she complained that any time she made a request for even basic information from the Plan, her office was "politely ignored." She further stated that though she was always concerned about their financial condition, of course, she lacked the authority to do anything about it.

During the course of its investigation, the Staff reviewed those financial statements filed with the three separate insurance regulators. In addition, the Staff reviewed the two most recent on-site examinations conducted of the Plan by Maryland in 1988 and by Virginia in 1992.

The Staff found that because D.C. lacked regulatory authority over GHMSI, the Maryland and Virginia Insurance Departments alternated responsibility for examinations of the Plan.

The Maryland Insurance Department's examination of the Plan at year-end 1987 made minor adjustments to the Plan's reported financial statement. For example, the regulator did not permit the Plan to claim as an asset the $5 million investment in Blue Cross of Jamaica, and disallowed $1.5 million in uncollected premiums that could not be substantiated.

In 1988, the Plan reported to the regulators a dramatic drop in reserves—to $8.2 million at year end. However, by year-end 1989, the company claimed reserves of over $103 million. The Staff has determined that this dramatic jump was attributed to the company listing its building at $80 million more than it had reported its value to be just a few months earlier. The Staff was told that the Virginia Insurance Department permitted this book entry because "GHMSI had found a loophole in the Virginia Insurance statute, which allowed the Plan to carry its headquarters at market value, rather than as previously listed, at cost. GHMSI, the Staff was told, had been unsuccessful in its attempts to sell and lease back its building. The Plan continues to carry its headquarters—a highly illiquid asset—at market value.

As the Subcommittee knows, the State insurance regulators rely heavily on the industry's external auditors to identify and, through annual audits, report on the financial condition of companies. In fact, all insurance companies in the United States are required to file audited financial reports with their State regulators. The requirement to file audited reports on a statutory basis began in 1991.

The Plan's only financial statement to be audited on a statutory basis was 1991. Price Waterhouse in its letter dated February 21, 1992 stated that the financial statement "presents fairly, in all material respects the admitted assets, liabilities, reserves and other funds of Group Hospitalization and Medical Services, Inc. as of December 31, 1991" on the basis of accounting "prescribed or permitted by the Virginia Bureau of Insurance." The statement listed total reserves and other funds as $101,962,000, exactly the same as the amount listed on the statutory blank filed with the Virginia Commission.

On February 21, 1992, the Virginia Department of Insurance initiated its on-site review of the Plan, to identify the issues that would be investigated during the full quadrennial examination—it was Virginia's turn to examine the Plan. The Staff has learned that the Virginia regulator, based on its recently completed examination (the report is not yet final), intends to set GHMSI's 1991 year-end reserve at $54.6 million—a $47.3 million difference from what the Plan's auditors had reported.

The Staff has discovered that during his examination, the Virginia regulator has taken exception to many of GHMSI's transactions, among them:

—several apparent violations of Virginia's holding company act;

—wholly unrealizable financial calculations by the corporation;

—material misstatements pertaining to asset valuation and unreported liabilities;

—the marketing of insurance products in Virginia without prior approval;

—alleged conflicts of interest; and

—transactions and expenses which were not "in the best interest of the subscribers."

The report will be made part of the hearing record when it becomes a public document.

The regulatory environment that GHMSI is subject to today is dramatically different than it has been in the plan's 60 years of existence. Today, the Plan is reacting to the harsh pressure of the Virginia Insurance Department, which has required the Plan to maintain 45 days of claims-paying ability in its reserves and, simultaneously, reinsure all of its Virginia risk business. This immense pressure comes at a time when GHSMI finds itself scrambling to meet those new requirements while it faces the immense losses created by its far-flung subsidiaries. The Plan, while admitting concern about its financial strength, has told the Staff that it questions whether Virginia's dual requirement of $46 million in reserves and 100 percent reinsurance of risk business is overly harsh.

The Staff also raises concern over the apparently inadequate reserve requirements currently in effect in the District of Columbia. D.C.'s minimum reserve level is only $1.5 million, not even 2 days' claims-paying ability for the DC Plan. Clearly, the D.C. City Council should address this area quickly.

Just within the past few months, the Plan has altered its 6-year history of staving off regulators and ignoring their inquiries. The regulators have told us that management, scrambling to save the remnants of the corporation, are cooperating, hoping the regulators will not "pull the plug" on this Blue Cross and Blue Shield Plan on which 1.1 million subscribers depend.

X. CONCLUSION

On September 24, 1992, when the Staff last appeared before the Subcommittee to discuss the results of its review of the Maryland Blue Cross/Blue Shield Plan, we noted that there was great similarity between what we had found in Maryland and in the West Virginia Plan that had failed in 1990. In doing so, the Staff expressed its hope that Maryland would not suffer the same tragedy. Since September, time and events have borne out our optimism. As a consequence of this Subcommittee's inquiry and the actions of state regulators, the Maryland Plan's new Chairman and Board of Directors have taken steps to turn the Plan around. The Maryland Plan still has a long way to go to redress the history of abuses and management mistakes, but, they have at least recognized their problems and embarked upon a strategy for financial recovery.

With the hope of similar results, the Subcommittee embarked upon its current review of the D.C. Plan. In order for this Plan to survive and effectuate its own recovery, the mistakes and excesses of the past must be identified and addressed. The Staff believes, to paraphrase George Santayana, if we do not know the history of how the Plan got to its present state, then, most certainly, we are condemned to repeat those same mistakes.

Our Nation and its taxpayers are now paying dearly for problems in other financial sectors that were often ignored in the past in the vain hope that they would be worked out. Simply put, the public has a right to know the complete story about the operations of the DC Plan and the Subcommittee has a responsibility to tell it. If our efforts, through this and future hearings, can raise the level of awareness among the public, regulators, and Plan officials themselves as to the need to ensure that these Plans are managed in the public interest, then we will have performed a valuable service.

In furtherance of that end, the Staff makes the following conclusions and recommendations:

1. The absence of effective regulation, inadvertently imposed by Congress, permitted excesses and mistakes by the Plan's senior management and Board to go undetected and unchecked for the 8 years of GHMSI's existence;
2. The Plan's wild expansion into foreign and domestic subsidiaries and affiliates seriously impacted the finances of the Plan and has brought it to its current state of affairs;
3. The Plan's officers committed gross errors of judgment and ignored the most basic tenets of good management in needless and excessive expenditures both here and abroad;
4. The Board of Trustees allowed these excesses and failed in its duty to assure that all business was conducted for the benefit of the subscribers;
5. The Blue Cross/Blue Shield National Association failed to adequately monitor and assess the operations of this Plan, thereby endangering its subscribers;

6. The current regulatory scheme for this Plan remains cumbersome and inadequate;

7. The District of Columbia should act swiftly to enact the appropriate legislation and regulations necessary to control this company; and,

8. Once accomplished, and in light of the abuses identified, Congress should enact legislation dissolving this Plan's Congressional charter.

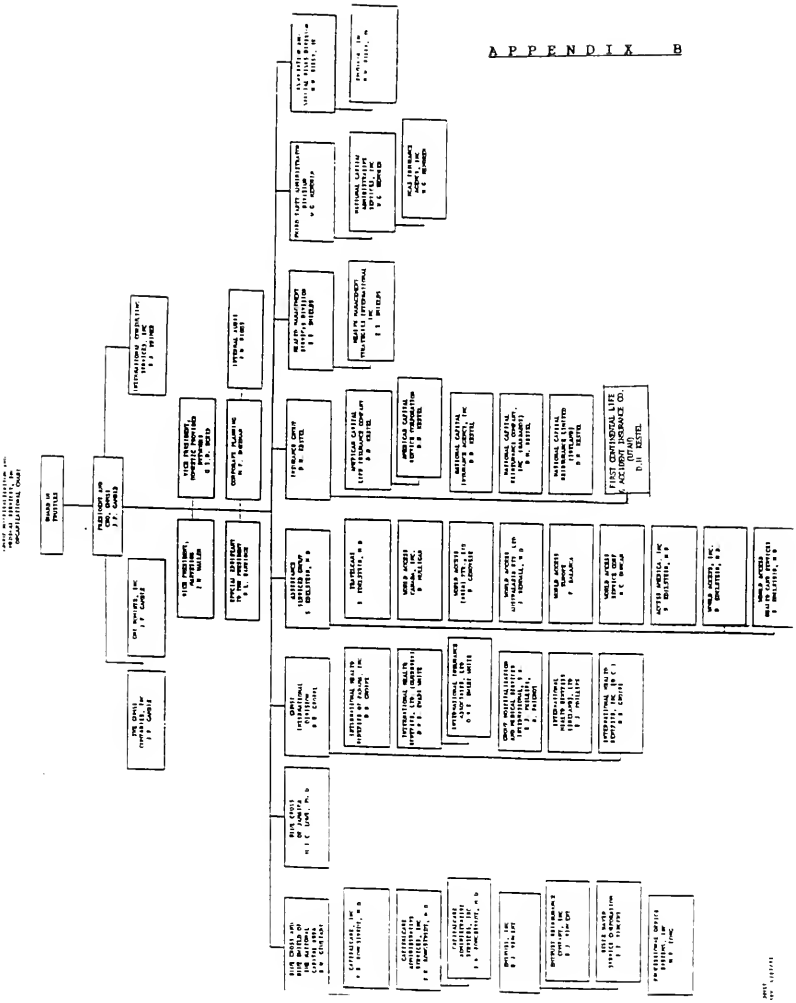
APPENDIX A

Group Hospitalization and Medical Services, Inc.
Time Line Organizational Development Summary

Date Incorporated/ Acquired	Company Name
August 11, 1939	Group Hospitalization and Medical Services, Inc.
April 20, 1978	National Capital Insurance Agency, Inc.
July 28, 1982	GHI Nominee, Inc.
July 1, 1983	World Access, Inc.
November 3, 1983	National Capital Administrative Services, Inc.
June 22, 1984	Capital Care, Inc.
January 10, 1985	Health Management Strategies International, Inc.
April 24, 1985	Access America, Inc.
June 27, 1985	Professional Office Systems, Inc.
October 22, 1985	International Health Benefits, Inc.
December 6, 1985	The GHMSI Companies, Inc.
April 22, 1986	Protocol, Inc.
April 23, 1987	Emtrust, Inc.
May 15, 1987	CapitalCare Administrative Services, Inc.
July 6, 1987	National Capital Reinsurance Company, Inc.
July 24, 1987	Blue Cross of Jamaica
November 13, 1987	World Access Australasia PTY Limited
December 8, 1987	NCAS Insurance Agency, Inc.
January 11, 1988	World Access Canada, Inc.
January 29, 1988	Emtrust Reinsurance Company, Inc.
February 8, 1988	American Capital Life Insurance Company
February 16, 1988	International Consulting Services, Inc.
April 4, 1988	International Health Benefits of Panama, Inc.
April 25, 1988	GHMSI SA
January 11, 1989	International Insurance Associates, Ltd.
January 11, 1989	International Health Benefits, Ltd.
January 24, 1989	Duncan Travel Services, Inc.
April 15, 1989	International Health Benefits (Ireland) Ltd.
April 16, 1989	World Access Ireland Limited
April 24, 1989	World Access Health Care Services
June 8, 1989	Belle Haven Service Crop.
August 22, 1989	World Access (Asia) Pte. Limited
November 1, 1989	American Capital Service Corp.
April 20, 1990	World Access Service Corp.
June 25, 1990	World Access Limited
January 1, 1991	International Claims Center E.U.R.L.
January 29, 1991	National Capital Reinsurance, Ltd.
March 4, 1991	Capital Area Services Company, Inc.
March 27, 1991	Capital Area Services Company, Inc.
April 19, 1991	Protocol Administrative Services, Inc.
October 24, 1991	Waterloo Insurance Brokers
December 9, 1991	GHMSI Partnership I, Inc.
January 13, 1992	World Access Medical Services PTY. Limited
April 17, 1992	First Continental Life and Accident Insurance Co.
July 1, 1992	World Access New Zealand Limited
August 1, 1992	World Access Europe

* * *

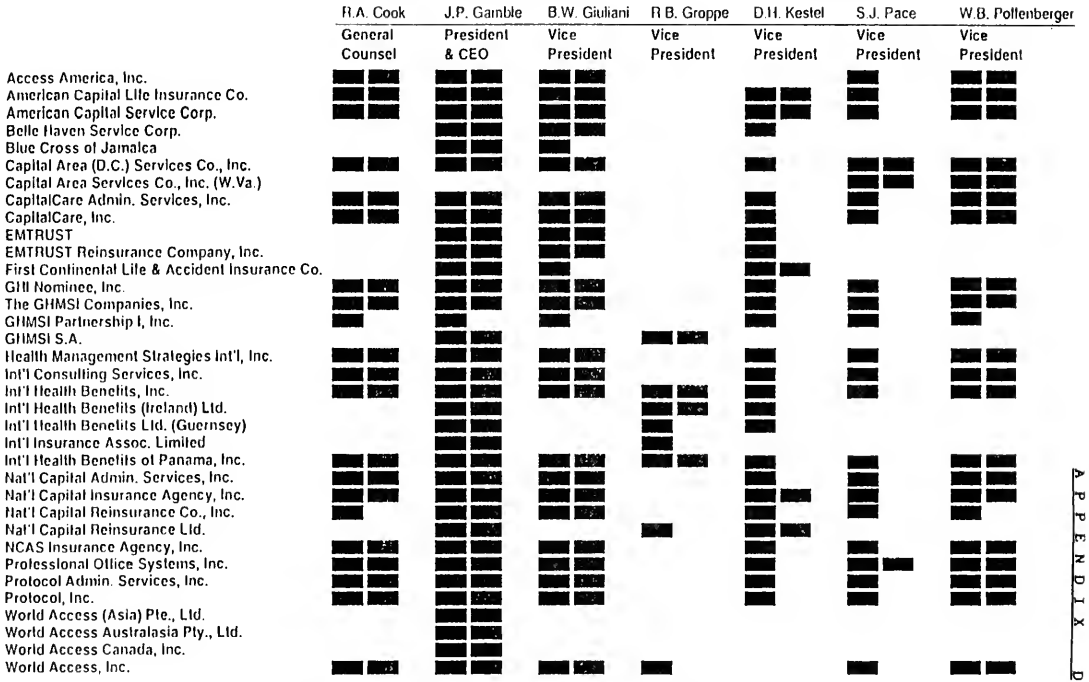
APPENDIX B



APPENDIX C

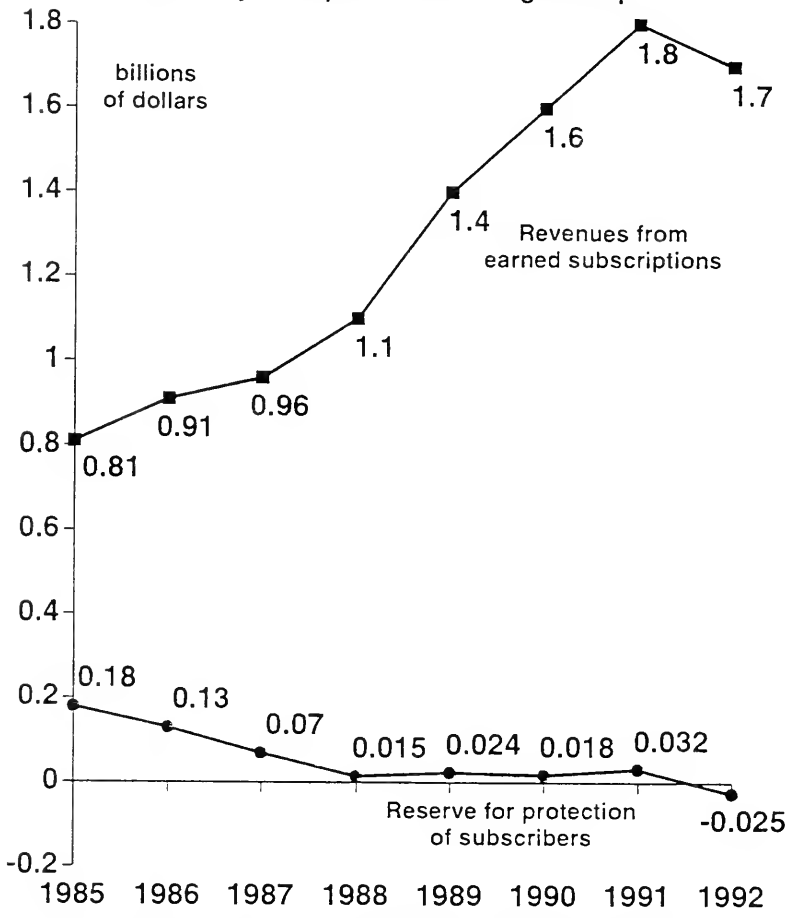
GROUP HOSPITALIZATION AND MEDICAL SERVICES, INC.
LEGAL CORPORATE STRUCTURE - AS OF DECEMBER 1, 1991

GHMSI SENIOR OFFICERS WHO WERE ALSO OFFICERS AND/OR DIRECTORS OF THREE OR MORE GHMSI SUBSIDIARY COMPANIES



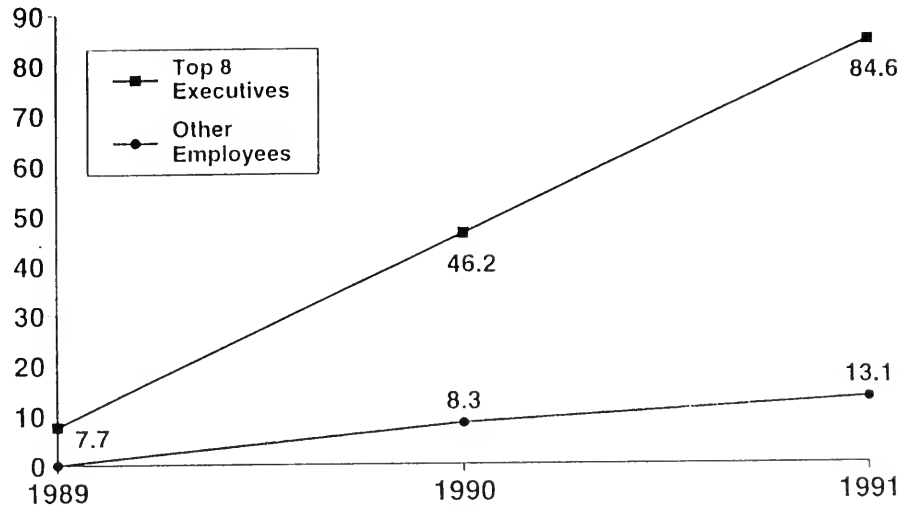
1/13/93 chl2

GHMSI
Relationship of Revenues & Reserves
Generally Accepted Accounting Principles



Source: GHMSI's audited consolidated financial statements (except '92)
1992 per GHMSI (projected)

GHMSI
Increase Since 1988 in Percentages of Salaries and Benefits of Top Eight Executives Compared to All Other Employees



	Top 8 Executives	All Other Employees
1989	$1.4 million	$90.6 million
1990	$1.9 million	$98.1 million
1991	$2.4 miilion	$102.5 million

1/13/93 chl3

APPENDIX G

BLUE CROSS AND BLUE SHIELD OF THE NATIONAL CAPITAL AREA

TRAVEL EXPENSE REPORT

CHECK NO.

(SEE REVERSE SIDE FOR INSTRUCTIONS)

NAME OF EMPLOYEE (Please Print)	EMPLOYEE DSU	PURPOSE OF TRIP	LOCATION
J. P. Gamble	AA10	Meetings & Regional Conference (IFVUSF) - February 22 - March 3, 1989	London, England Paris, France Harare, Zimbabwe

TOTAL EXPENSES

DATE	2/22/89						3/3/89	TOTAL EXPENSES
MEALS and BEVERAGES								
TAXI, LIMO OR BUS							25 00	25 00
ENTERTAINMENT (Explain below)								
TRANSPORTATION: AIR (X) RAIL ( )	3631 00							3631 00
HOTEL/MOTEL	1185 32							1185 32
REGISTRATION FEE								
AUTO (Number of Miles ____)								
OTHER (EXPLAIN BELOW)	3061 76							3061 76
TOTAL	7878 08						25 00	7903 08

EXPENSES PREPAID OR CHARGED TO BCBSNCA

ORGANIZATION TO WHOM CHECK WAS/WILL BE DRAWN	INDICATE PREPAID (P) OR CHARGED (C)	GENERAL DESCRIPTION OF ITEM(S)	AMOUNT
American Airlines	C	Airfare	6371 78 *

* Credit will be given for a portion of the airfare.

EXPLANATION OF ENTERTAINMENT & OTHER EXPENSES — TOTAL EXPENSES PREPAID OR CHARGED 6371 78

All items reported as entertainment must be described below with date(s), persons entertained and their organization.

All items reported above as "other" must be described below.

GHMSI 6B2:00218

Other: $2,740.78 - Corporate Account
198.14 - Taxi, Tips & Malaria pills
86.50 - Misc. shots
26.34 - Tips (Harare)
10.00 - Airport tax (Harare)

We certify that these expenses were incurred in accordance with BCBSNCA travel policy guidelines and that they represent prudent, reasonable and necessary expenses incurred in the performance of Company business.

SUBMITTED BY: J. P. Gamble DATE April 17, 1989

DSU TO BE CHARGED: AA10

LINE OF BUSINESS IMPACTED: All DSU Business
(E.G. All DSU Business, NON-FEP, Medicare A, FEP Operations Center, FEP-Institutional, etc.)

APPROVED BY: J. P. Gamble DATE April 17, 1989

J. P. Gamble — April 17, 1989
APPROVED FOR PAYMENT — DATE

SETTLEMENT

TOTAL EXPENSES	7903 08
LESS: PERSONAL EXPENSES	-- --
BALANCE	7903 08
LESS TOTAL EXP. PREPAID OR CHARGED TO BCBSNCA	6371 78
BALANCE	1531 30
LESS: TRAVEL ADVANCE	-- --
NET DUE EMPLOYEE OR (BCBSNCA)	1531 30

If BCBSNCA is to be reimbursed by another organization for all or a portion of this expense, specify the organization and the amount. (See instruction "I" on back.)

BCBSNCA TO BE REIMBURSED BY — AMOUNT

REMEMBER YOUR PASSPORT

copy to JK ✓ 2/22
copy to H.W.N. ✓ 2/22 (1-11) MAJIC

Meetings
London, England
Paris, France
February 22-24, 1989
Mr. J. P. Gamble

Regional Conference (IFVHSF)
Harare, Zimbabwe
February 25 - March 3, 1989
Mr. J. P. Gamble

N-12.45 JPG & DHK club @ Red carpet @ airport 661-7593

Wednesday, February 22, 1989 -
11:30 a.m. - Dave Kestel will drive you and himself to Dulles Airport.

Depart Wash/Dulles (IAD)	1:00 PM	British Airways 188/R Mr. Gamble - Seat 3B Mr. Kestel - Seat 3C
Arrive London (LHR)	10:00 PM	Nonstop, Concorde Service

Accommodations in London (1 night, February 22 - Mr. Gamble)
(3 nights, February 22-24 - Mr. Kestel)
London Marriott Hotel
10 Grosvenor Square
London, England
Telephone: 011-44-1-4931232
Telex: 268101
Confirmation No.: 89393Q4Q - Mr. Gamble
8038XJ3Q - Mr. Kestel

NOTE: JPG - Buy your malaria pills!

Thursday, February 23, 1989 -
AM/PM - Meetings with Dave Kestel.

PM - Depart London (LHR)	2:30 PM	British Airways 312/Bus. Class
Arrive Paris (CDG)	4:30 PM	Nonstop, 757

PM - Francois will pick you up at the airport.

PM - Briefing with Francois.

8:00 p.m. - Dinner with Rene' Teulade and Francois Balanca.

Accommodations in Paris (1 night, February 23)
Grand Hotel Inter-continental-Paris
2 Rue Scribe
Paris, France
Telephone: 011 3314 268 1213
Telefax: 426-61251
Telex: 842-220875
Confirmation No.: Reservation made by Francois.

GMT: 0412:02600

9

Friday, February 24, 1989 -
AM - Francois will take you to the airport.

AM - Depart Paris (CDG)	9:30 AM		British Airways 303/Bus. Class
Arrive London (LHR)	9:30 AM		Nonstop, 757

NOTE: A day room has been arranged for you at the Excelsior Hotel (at LHR airport)--compliments of British Airways--pick up voucher from the transfer desk at LHR airport before going through immigration and customs.

AM/PM - Meetings with Dave Kestel.

MR. GAMBLE'S PLANE RESERVATION -

PM - Depart London (LHR)	9:10 PM		British Airways 53/FC, Seat 2B
Arrive Harare, Zimbabwe (HRE)	9:05 AM	2/25/89	Nonstop, 747

Saturday, February 25, 1989 -
DAVE KESTEL'S PLANE RESERVATION -

AM - Depart London (LHR)	11:45 AM		British Airways 217/FC, Seat 3A
Arrive Wash/Dulles (IAD)	3:10 PM		Nonstop, 747

Accommodations in Zimbabwe (9 nights, February 24-March 4)
Meikles Hotel
Stanley Avenue & 3rd Street
Harare, Zimbabwe
Telephone: 011263 (4) 795655
Telefax: 707754
Telex: 26063
Confirmation No.: (Made directly with hotel--hotel does not give confirmation number.)

Sunday, February 26, 1989 -
Registration

6:00 p.m. - Meeting of Speakers and Chairmen

7:00 p.m. - 10:30 p.m. - President's Reception (An informal opportunity for delegates and speakers to meet)

Monday, February 27, 1989 -
7:30 a.m. - Communal Breakfast

9:00 a.m. - Opening Session
Chairman: Richard Hore, General Manager, CIMAS (Zimbabwe)
Conference Chairman

Speakers: David P. Wadman, Chairman, NAMAS (Zimbabwe)
Robert M. Graham, Chief Executive, BUPA (UK)
President, IFVHSF

Monday, February 27, 1989 (continued) -
9:35 a.m. - The IFVHSF Role and Priorities

(The IFVHSF exists to promote medical aid and support its members. The Secretary-General will explain how it seeks to do this, what the Federation's priorities are and how they are determined.)

Chairman: Tom Lawes (Public Services MAS)

Speaker: Kenneth N. Groom (Secretary-General, IFVHSF)

10:30 a.m. - Refreshments

11:00 a.m. - Value for Money in Administrative Systems

(All medical funds strive to control administrative costs. However, in all funds part of the administration function is to control the overall costs. The best administrative performance is not, therefore, that which operates the administrative function at least cost. But rather it is that which obtains the best value for the expenditure on administration in terms of the total operations of the fund - payment of health care costs and the costs of the administrative function itself.)

Chairman: Patyai Mubonderi, NAMAS Board (Zimbabwe)

Speakers: Thomas R. Ryan, General Manager, Voluntary Health Insurance Board (Ireland)
John D. Seney, Executive Director, Medical Services Assn. (Canada)

12:30 p.m. - Cash Bar

1:00 p.m. - Communal Lunch

2:00 p.m. - Alternative Delivery Systems and Managed Care

(The traditional fee-for-service payment system is being displaced by other approaches - health maintenance organizations, preferred provider arrangements, etc. These, and managed care systems, restrict the freedom of choice of subscribers and providers in return for savings on the overall cost of care. In a workshop session the concepts will be explained in plenary format then their applicability to other countries and significance to southern Africa will be discussed in a workshop session.)

Chairman: J. Colin L. Rees (Engineering Medical Fund)

Speaker: Bernard R. Tresnowski, President, BCBSA (USA)

2:30 p.m. - International Workshop on ADS and Managed Care

3:30 p.m. - Refreshments

Monday, February 27, 1989 (continued) -
4:00 p.m. - 5:00 p.m. - Panel Discussion

(It is a rare opportunity for medical aid funds in southern Africa to have the opportunity of hearing from the world's medical aid leaders. So in order to ensure that questions covered by the conference agenda can be pursued in further depth and to ensure that questions not on the agenda can be raised, each day will end with a free-for-all panel discussion where any questions can be fired at the international speakers.)

Chairman: Richard Hore, Conference Chairman

Speakers: All Monday's speakers as panel

7:00 p.m. - Cocktails and Dinner

Tuesday, February 28, 1989 -
7:30 a.m. - Communal Breakfast

9:00 a.m. - Value for Data Processing Money

(One key to operating efficient medical aid funds is good data processing systems. Three speakers in this plenary session will explain how, in their countries, they are solving the problem of getting value for data processing money.)

Chairman: David R. Riley, General Manager, Railmed (Zimbabwe)

Speakers: Leon R. Furlong, President, Blue Cross of Atlantic Canada
Robert Van den Heuvel, President, Alliance Nationale des Mutualites Chretiennes (Belgium)
James Mansfield, Chief General Manager, Mutual Community (Australia)

10:30 a.m. - Refreshments

11:00 a.m. - The Detection and Prevention of Fraud

(The abuse of a medical aid contract can be either unethical or illegal [or both]. For example, the delivery of medically unnecessary treatment may be unethical but it is not usually illegal. This session will address the illegal aspect of the problem. An outline of approaches to detect and prevent fraud will be given in plenary format. The applicability of these approaches to other countries and in the context of southern Africa will be debated in a workshop session.)

Chairman: R. E. Clark, (MAS of Central Africa)

Speaker: Joseph P. Gamble, President and CEO, Group Hospitalization and Medical Services, Inc. (USA)

11:30 a.m. - International Workshop on Medical Aid Fraud

Tuesday, February 28, 1989 (continued) -
12:30 p.m. - Cash Bar

1:00 p.m. - Communal Lunch

2:00 p.m. - Medical Aid in a Free Market

(Medical aid funds which do not give value for money risk losing subscribers to more efficient funds operating in the same market place. This plenary session will give the experience of funds in two countries where funds compete for subscribers in a free market.)

Chairman: Michael Chalk (CIMAS)

Speakers: Jan H. Bok, President, Zilveren Kruis (Netherlands)
Anthony M. Leveton, Principal Officer, Consolidated Employers Medical Aid Society (South Africa)

3:00 p.m. - Refreshments

3:30 p.m. - Panel Discussion

Chairman: Richard Hore, Conference Chairman

Speakers: All Tuesday's speakers as panel

4:20 p.m. - Closing Address: Robert M. Graham, (UK) President IFVHSF

4:30 p.m. - End of Conference

Wednesday, March 1, 1989 - Thursday, March 2, 1989 -
Council Meeting

Zimbabwean NAMAS will host a dinner for members of Council on March 1.

Thursday, March 2, 1989 -
AM - Depart Harare, Zimbabwe (HRE) 10:15 PM British Airways 52~~/Bus. Class~~,
Arrive London (LHR) 6:25 AM 3/3/89 Seat ~~17B~~, Nonstop, 747
~~(EQ Preferred)~~

Friday, March 3, 1989 -
NOTE: A day room has been arranged for you at the Excelsior Hotel (at LHR airport)--compliments of British Airways—pick up voucher from the transfer desk.

GH181 04:02604

Friday, March 3, 1989 (continued) -

AM - Depart London (LHR)	11:45 AM	British Airways 217/~~Bus. Class~~ FC
Arrive Wash/Dulles (IAD)	3:10 PM	Nonstop, 747
		(FC waitlisted) Seat 4J

If FC doesn't clear on BA 217 --

AM - Depart London (LHR)	10:30 AM	British Airways 1/R, Seat 11B
Arrive New York (JFK)	9:20 AM	Nonstop, Concorde Service

(Surface transportation)

Depart New York (LGA)	11:55 AM	United Airlines 1427/FC, Seat 3B
Arrive Wash/Dulles (IAD)	1:01 PM	Nonstop, Snack, 72S

PM - No transportation arrangements have been made from Dullea Airport.
(Take a cab home)

FC=$6,371.78, Y=$3,631.00, Round-trip
Diane
February 21, 1989

GHMSI 642:02605

REMEMBER YOUR PASSPORT

Meeting
London, England
February 22-24, 1989
Mr. and Mrs. J. P. Gamble

Regional Conference (IFVHSF)
Harare, Zimbabwe
February 25 - March 6, 1989
Mr. and Mrs. J. P. Gamble

Wednesday, February 22, 1989 -
AM - No transportation arrangements have been made to Dulles Airport.

Depart Wash/Dulles (IAD)	1:00 PM	British Airways 188/R Mr. Gamble - Seat Mrs. Gamble - Seat Mr. Kestel - Seat
Arrive London (LHR)	10:00 PM	Nonstop, Concorde Service

Accommodations in London (3 nights, February 22-24 - Mr. and Mrs. Gamble)
London Marriott Hotel (3 nights, February 22-24 - Mr. Kestel)
Grosvenor Square
London, England
Telephone: 011-44-1-4931232
Telex: 268101
Confirmation No.: - Mr. and Mrs. Gamble
- Mr. Kestel

Thursday, February 23, 1989 -
AM/PM - Meeting

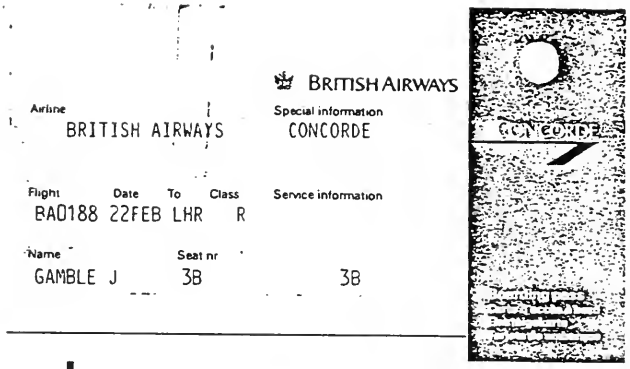
Friday, February 24, 1989 -
AM/PM - Meeting

MR. AND MRS. GAMBLE'S PLANE RESERVATION -

PM - Depart London (LHR)	9:10 PM	British Airways 53/R Mr. Gamble - Seat Mrs. Gamble - Seat
Arrive Harare, Zimbabwe (HRE)	9:05 AM 2/25/89	Nonstop, 73S

Saturday, February 25, 1989 -
DAVE KESTEL'S PLANE RESERVATION -

PM - Depart London (LHR)	13:00 PM	British Airways 189/R, Seat
Arrive Wash/Dulles (IAD)	12:15 PM	Nonstop, Concorde Service



BRITISH AIRWAYS

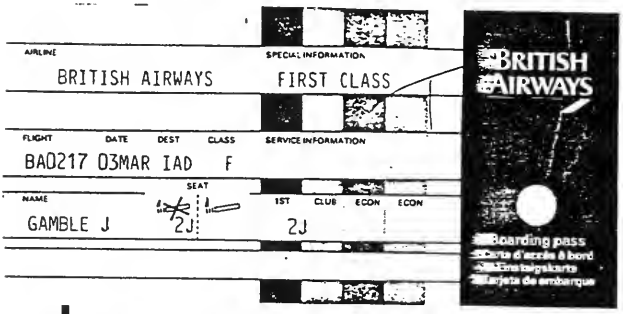
Airline
BRITISH AIRWAYS

Special information
CONCORDE

Flight Date To Class Service information
BA0188 22FEB LHR R

Name Seat nr
GAMBLE J 3B 3B

CONCORDE

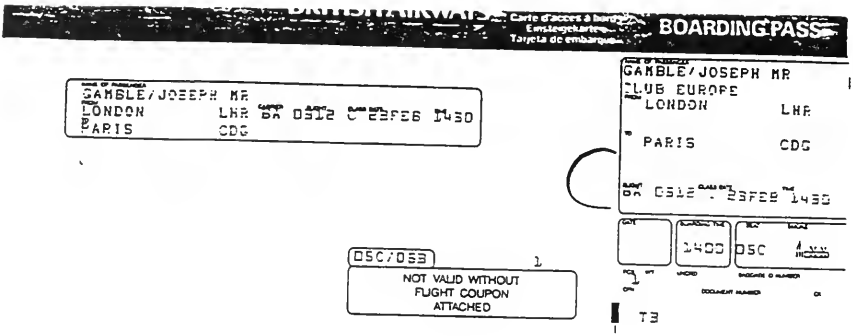


AIRLINE SPECIAL INFORMATION
BRITISH AIRWAYS FIRST CLASS

FLIGHT DATE DEST CLASS SERVICE INFORMATION
BA0217 03MAR IAD F

SEAT
NAME 1ST CLUB ECON ECON
GAMBLE J 2J 2J

BRITISH AIRWAYS
Boarding pass
Carte d'accès à bord
Einstiegskarte
Tarjeta de embarque



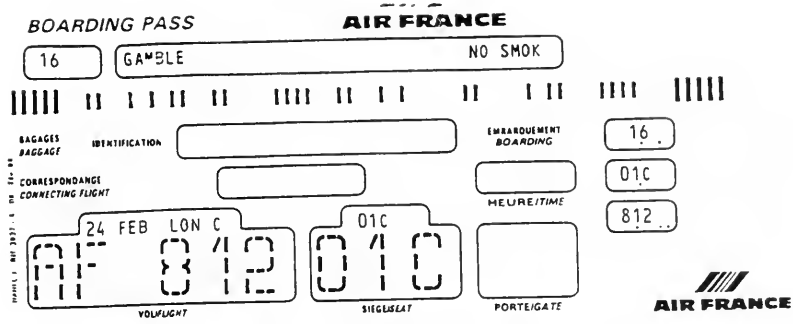
BRITISH AIRWAYS Carte d'accès à bord Einstiegskarte Tarjeta de embarque BOARDING PASS

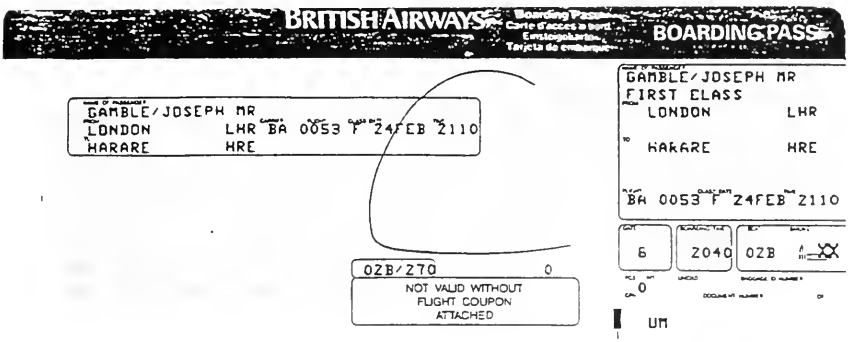
GAMBLE/JOSEPH MR
LONDON LHR BA 0512 C 23FEB 1430
PARIS CDG

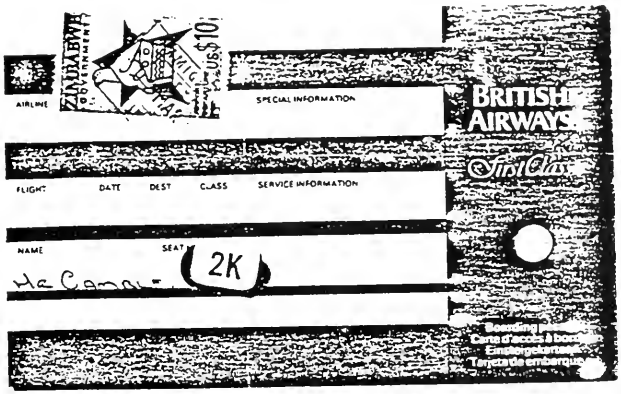
GAMBLE/JOSEPH MR
CLUB EUROPE
LONDON LHR
PARIS CDG
BA 0512 23FEB 1430
1400 050

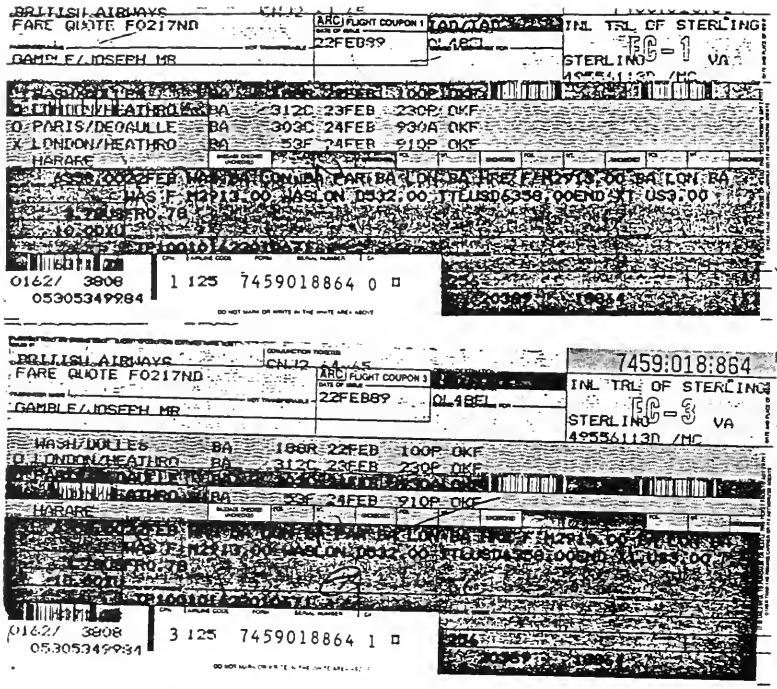
050/053
NOT VALID WITHOUT FLIGHT COUPON ATTACHED

TB


BOARDING PASS
AIR FRANCE
16
GAMBLE
NO SMOK
BAGAGES / BAGGAGE
IDENTIFICATION
EMBARQUEMENT / BOARDING
16
CORRESPONDANCE / CONNECTING FLIGHT
HEURE/TIME
01C
812
24 FEB LON C
AF 812
01C
VOL/FLIGHT
SIEGE/SEAT
PORTE/GATE
AIR FRANCE


BRITISH AIRWAYS
BOARDING PASS
GAMBLE/JOSEPH MR
LONDON LHR BA 0053 F 24FEB 2110
HARARE HRE
GAMBLE/JOSEPH MR
FIRST CLASS
LONDON LHR
HARARE HRE
BA 0053 F 24FEB 2110
6
2040
02B
02B/270
NOT VALID WITHOUT FLIGHT COUPON ATTACHED
UM


AIRLINE
SPECIAL INFORMATION
BRITISH AIRWAYS
FLIGHT
DATE
DEST
CLASS
SERVICE INFORMATION
NAME
SEAT
2K



Voided tickets

- sent to Mary for credit on 4/12/89 DN

GHMSI 642:02630

Thank you for choosing the London Marriott Hotel on your trip to the United Kingdom. We trust your stay was enjoyable, and hope to see you again soon. At your convenience we would certainly appreciate your comments on our "Will You Let Me Know" form. We appreciate your business and continued patronage.

104 GAMBLE/JOSEPH MR		145.00	24/02/89		ACCT#
NAME		RATE	DEPART	TIME	7019
DR BLUE CROSS BLUE SHIE			22/02/89	23: 9	
FIRM OR GROUP		PLAN	ARRIVE	TIME	

25 PRES
WASHINTON DC AX372827177031005/03
20024
ADDRESS PAYMENT

DATE	REFERENCE		CHARGES	CREDITS	BALANCE DUE
/02	ROOM	404, 1	145.00		
/02	RM TAX	404, 1	21.75		
/02	ROOM	404, 1	145.00		
/02	RM TAX	404, 1	21.75		
/02	TELEPHON	195-9010	14.11		
/02	TELEPHON	199-9723	.68		
/02	TELEPHON	201-9010	19.55		

367.84=

US $643.83

he undersigned agrees to make immediate payment upon receipt of statement. In the event such payment is not ade within 25 days after receipt of the original statement, it is agreed that the hotel may immediately impose a ATE PAYMENT CHARGE at the rate of 1½% per month (ANNUAL RATE 18%), or the maximum allowed by law, n the unpaid balance, and the reasonable cost of collection, including attorney fees.

gnature X _____

GHMSI 6B2:00220

LONDON Marriott GROSVENOR SQUARE, LONDON W1A 4AW, ENGLAND
TELEPHONE 01-493 1232 TELEX 261 101 LONMAR G

MEIKLES HOTEL

L******

P.O. BOX 594, HARARE, ZIMBABWE
TELEPHONE 795655, TELEX 6063 FAX 707754
TELEGRAM "TRAVELLER"

SURNAME: GAMBLE
FIRST NAMES: J.P.
FULL RATE: 115.20
LESS DISC:
NET RATE: 115.20
CR CARD: AMEX

ARR DATE: 25/02/89
DEP DATE: 02/03/89
ROOM NO: 468
STATEMENT NO: 1
BILL NO: 20998

DATE	DESCRIPTION	DEBIT	CREDIT
25/02/89	ACCOMMODATION TOWER BLOCK	115.20	
25/02/89	GOVERNMENT LEVY	0.60	
25/02/89	TELEPHONE CALLS	11.51	
25/02/89	TELEPHONE CALLS	74.42	
25/02/89	COFFEE SHOP RESTAURANT	12.45	
25/02/89	COFFEE SHOP BAR	3.00	
25/02/89	CAUSERIE/ROOM SERVICE BAR	31.65	
25/02/89	CAUSERIE/ROOM SERVICE BAR	2.20	
26/02/89	ACCOMMODATION TOWER BLOCK	115.20	
26/02/89	GOVERNMENT LEVY	0.60	
26/02/89	TELEPHONE CALLS	88.15	
26/02/89	TELEPHONE CALLS		66 015.00
26/02/89	TELEPHONE CALLS	66 015.00	
26/02/89	COFFEE SHOP RESTAURANT	2.70	
26/02/89	COFFEE SHOP RESTAURANT	9.40	
26/02/89	COFFEE SHOP BAR	1.50	
26/02/89	CAUSERIE/ROOM SERVICE BAR	3.00	
27/02/89	ACCOMMODATION TOWER BLOCK	115.20	
27/02/89	GOVERNMENT LEVY	0.60	
27/02/89	TELEPHONE CALLS	41.75	
27/02/89	LAUNDRY	6.20	
27/02/89	LAUNDRY	7.50	
27/02/89	ROOM SERVICE	17.00	
27/02/89	CAUSERIE/ROOM SERVICE BAR	1.10	
27/02/89	CAUSERIE/ROOM SERVICE BAR	3.15	
28/02/89	ACCOMMODATION TOWER BLOCK	115.20	
28/02/89	GOVERNMENT LEVY	0.60	
28/02/89	TELEPHONE CALLS	74.42	
01/03/89	ACCOMMODATION TOWER BLOCK	115.20	
01/03/89	GOVERNMENT LEVY	0.60	
01/03/89	TELEPHONE CALLS	32.82	
01/03/89	LA FONTAINE RESTAURANT	4.00	
01/03/89	CAUSERIE/ROOM SERVICE BAR	1.10	
02/03/89	LA FONTAINE RESTAURANT	4.00	
	ACCOUNT BALANCE	1 369.18 =	

GUESTS SIGNATURE: _____ US$ 541.49

GHMSI 6A2:0261s

IFTHSF REGIONAL CONFERENCE
HARARE, 26 - 28 FEBRUARY 1989

DELEGATES

NAME	FIRST NAME	TITLE/POSITION	FUND	ACCOMPANYING PERSON
BELGIUM				
MR R VAN DEN HEUVEL	ROBERT	President	Alliance National Des Mutualites Chretiennes	
CANADA				
MR L FURLONG	LEON	President & Chief Executive Officer	Blue Cross of Atlantic Canada	CATHY
MR J D SENET	JOHN D	Executive Director	Medical Services Association	-
EGYPT				
DR H DIAB				
IRELAND				
MR T R RYAN	THOMAS R	General Manager	Voluntary Health Insurance Board	TERRY
MALAWI				
MR R D MALIMBA	REG D	General Manager	Medical Aid Society of Malawi	-
MR D E J MASINGA	JOE	Deputy Chairman	Medical Aid Society of Malawi	
NAMIBIA				
MR P J B COETZER	PIETER J	Chairman	NASMED	-
MR D T VERHEULEN	URBAN T	Principal Officer	O & L Group Medical Fund	-
MR A P WAHL	ANDRIES P	Committee Member	NASMED	-
NETHERLANDS				
MR J H POX	JAN H	President	Silver Cross	-
SOUTH AFRICA				
MR G J BARNARD	GIDEON J	General Manager	Cape Medical Plan	-
MR R H BASSON	ROB H	Chief Executive	National Medical Plan	-
MR C E BERMAN	CLIVE E	Managing Director	Medical Expenses Distribution Society (Meds)	-
MRS M A BESTER	MARIA	Personnel Manager	Mercantile & General Reinsurance Co Ltd	GEORGE
MR C D BEUKES	CYRIL D	Vice Chairman	Pro Sano Medical Aid	-
MR P BOOKER				
MR E A BOTHA	BASSIE	Manager Admin.	Ferromed	
MR J M J BOTHMT	J M J	General Manager	MIMED Medical Aid Society	-
MR M J BUTTON	MALCOLM J	Manager	Chartered Accountants (SA) Medical Aid Fund	-
MR R T DUYS	ROLI T	General Manager	Vaalmed	-
MR M A CROSS	MIKE	General Manager	Midland Medical Plan	SHIRLEEN
MR E H DAVEL	KEN H	Secretary	Building Industry Medical Fund, Port Natal	
MR R DAVEL	ROB	Principal Officer	Nosmed	-
MR J A DE KLERK	JOHAN A	General Manager	Bankmed	
MR J J M DU PREEZ	NICK	General Manager	Sanmed	-
MR M R EWING	NEVILLE R	Assistant Manager	Eskom Medical Aid Society	-
MR P A FALLA		Chairman	Hoart Medical Aid Society	
MR E FREY	ED	Director	National Medical Plan	MERLE
MRS A FROST	ANDRIE	Assistant Secretary	Highveld Medical Scheme	
MR A M HARWOOD	TONY M	Marketing Manager	M C I Medical Scheme	-
MR R F C HOLLIS	KEITH F C	Principal Officer	Finmed Medical Aid Scheme	MARLENE
MR L D HOLLIS	LES D	Company Director	Medical Services Plan	ANN
MR M B HOPEWELL	BRUCE	Director	National Medical Plan	-
MR A M JACKSON	ANDREW	Principal Officer	Sanlite Medical Scheme	CAIL
MRS S JONES	SUE	Public Relations Manager	Chartered Accounts (SA) Medical Aid Fund	-
MR L W KEARNS	LIONAL W	Committee Member	Pro Sano Medical Aid Scheme	-
MR J D KRICE	DAN	Chairman	University of Natal Medical Scheme	SARAH
MR A K LAMBERT	KEITH	Chairman	Finmed Medical Aid Scheme	

NAME	FIRST NAME	TITLE/POSITION	- 2 - FUND	ACCOMPANYING PERSON
SOUTH AFRICA (Cont.)				
MR A M LEVETON	TONY	Principal Officer	Consolidated Employers Medical Aid Society	ANNE
MR S S LEVETON	SHAUN S	Manager - Marketing	Consolidated Employers Medical Aid Society	
MR D LEVY	DAVID	General Secretary	Medical Benefit Society for Clothing Industry	
DR N LEVY	NORMAN	Medical Consultant	Bankmed	-
MS P LUDORF	PENNY	Management Consultant	Pim Goldby Medical Aid	-
PROF P C LUTHULI	PAUL C	Chairman	Bonitas Medical Aid Fund	ALFINAH
MR J A McDONALD	JOHN A	Vice Chairman	Rennies Group Medical Aid Society	-
MR P McNULTY	PATRICK	Chairman	AECI Medical Aid Society	-
MR B M MOFOKENG	BERMAN	Vice Chairman	Bonitas Medical Aid Fund	GRACE
MR B M MURRAY	BRIAN	Chairman	Eskom Medical Aid Society	
MR A D NAUDE	ALAN D	Director	Affiliated Medical Administrators	
MR S H PEARSON	STEWART	Secretary	Chamber of Mines Medical	-
MR L T PETER	LES	Vice Chairman	Sanitas Medical Scheme	-
MR Q ROBINSON		Principal	K W B Medical Aid Society	
MR R E ROWE	RICHARD E	General Manager	N B C Medical Aid Society	-
MR A SCHRAAR	ALEX	Representative	Bonitas Medical Aid Fund	
MR L SCOTT	L	Managing Director	Affiliated Medical Administrators	MRS E
MR B M SHEPPY	BRUCE	Assistant Secretary	Northern Medical Aid	-
MR R J K SLATER	ROB J K	General Manager	National Medical Plan	-
MR J M SLOME	JEFF M	Principal Executive	Meddeot Medical Aid Insurance Board	-
MR P J SPANGENBURG	PETER	Group Medical Aid Manager	S A Mutual Life Assurance Society Staff	MYRA
MR H J STRIDOM	HENRI	Medical Aid Manager	D I M A F (WP) Society of Malawi	
MR G E D THIERRY	DIETER E D	Consultant, Medical Aid	M.C.I. Medical Fund	
DR C H C THOMAS	CHARLES	Deputy Chairman	Anglo American Corp. Medical Aid Society	
MR E R THOMAS	ERNEST R	Manager	Bankmed	-
MR M VAN NIEKERK	M	Director	Multimed Medical Scheme	-
MR J D VAN ZYL	KOBUS	Manager	Statutory Organisations Medical Scheme	-
MR B WYNTER	BRIAN	General Manager	M C I Medical Scheme	
UNITED KINGDOM				
MR R M GRAHAM	BOB M	Chief Executive	BUPA	EILEEN
DR K M GROOM	KEN M	Secretary General	International Federation of Voluntary Health Service Funds (IFVHSF)	MARY
MS J LOZE	JANET	Assistant to Secretary General	International Federation of Voluntary Health Service Funds	
DR P DELANEY	PAULINE	Director	Aveo	
UNITED STATES OF AMERICA				
MR J P GAMBLE	JOSEPH	President & Chief Executive Officer	Group Hospitalization & Medical Services Inc.	CAROLE
MR D R TRESNOWSKI	HARNEY R	President	Blue Cross & Blue Shield	LEANNE
ZIMBABWE				
MRS A AKINO	ANNIE	Secretary	Chibuku Breweries Ltd Medical Fund	-
MR M CHALE	MIKE	Medical Aid Manager	CIMAS Medical Aid Soc.	BARBARA
MRS E CHAPMAN	ELLA	Secretary	Union Carbide Medical Benefit Society	-
MR R E CLARE	RON E	Manager	MASCA Medical Aid Soc.	-
MR A C DEVLIN	TONY C	Committee Member	Anglo American Corp. Medical Aid Society	MOIRA
MR C Z DUBE	CUTHBERT Z	Assistant Secretary	Public Services	SILVIA
MR R G M FERGUSON	R G M	Board Member	Engineering Medical Fund	-
MRS A M FERREIRA	ANN-JEANETTE M	Assistant Secretary	Engineering Medical Fund Medical Aid Society	-

NAME	FIRST NAME	TITLE/POSITION	FUND	ACCOMPANYING PERSON
ZIMBABWE (Cont.)				
MS V O GAWE	VICTORIA G	Chairperson	Zimpapers Medical Benefit Society	S KAMANGA
MRS E M GUTA	ELIZABETH	Pharmacist In Charge	Railmed	
MR R HORE	RICHARD	General Manager	CIMAS Medical Aid Society	JOAN
MR B W IRWIN	B W	Secretary	Construction Industry Medical Fund	-
MR M JENNINGS	MIKE	Chairman	Engineering Medical Fund	CAROLINE
MR D KADASA	OLIVER	Committee Member	Engineering Medical Fund	-
MR E KANGURU	DENNIAS	Secretary	Zimpapers Medical Benefit Society	-
MR T KATSAMBA	TICHAKURU	Chief Clerk	Engineering Medical Fund	-
MR F KAZHANJE	F	Secretary	Itaco Medical Benefit Soc.	-
MR J S KONA	JAMES	Secretary	Anglo American Corporation Medical Aid Society	ELSIE
MR Y LAWES	TOM	Secretary	Public Services Medical Aid Society	-
MR D MANIKA	DICKSON	Chief Clerk	Engineering Medical Fund	-
MR V MANGOMA	VINCENT	Board Member	Railmed	
DR J M MARSON	JOHN M	Medical Consultant	Anglo American Corporation Medical Aid Society	MRS MARSON
MR P MASVIKENI	PATRICK	Marketing Manager	CIMAS Medical Aid Society	-
MR C C MAZENGERA	C C	Section Accounting Officer	Municipality of Bulawayo Medical Aid Society	-
MRS T MHLANGA		Senior Admin.Officer	Engineering Medical Fund	-
MR J MOTO	JEPHIAS	Board Member	Engineering Medical Fund	-
MR P MUBOWDERI	PATTAI	Board Member	Northern Medical Aid Society	-
MRS V MUCHEGWA		Secretary	Zimbabwe Glass Industries Medical Aid Society	
MRS E NORMAN	ELIZABETH	Board Member	MASCA Medical Aid Society	-
MR S RIGWARIE	SIMON	Board Member	MASCA Medical Aid Society	-
MR J A W PEEW	JAN	Board Member	CIMAS Medical Aid Society	JENNIFER
MR J C L REES	COLIN	Secretary	Engineering Medical Fund	-
MR D R RILEY	DAVID R	General Manager	Railmed	-
MRS E STEVENSON	ELKE	Secretary	Rio Tinto Group	-
MR R TARAVIRA	RODERICK	Systems Manager	CIMAS Medical Aid Society	
MISS R E TOMKIN	ROBIN E	Administrative Secretary	MAMAS	-
MR D P WADMAN	DAVID P	Chairman	MAMAS	JOYCE
MR R WEBBER	RON	Manager Finance	CIMAS Medical Aid Society	SHIRLEY
R S S WHITING	SHEVAUN	Secretary	OASIS Group Medical Aid	
MR A WILLIAMS	ALBAN	Manager	MASCA Medical Aid Society	-
MRS M A WILSON	MARY-ANNE	Personnel Officer	Legal and General Medical Aid Society	JIMMY
MR E R WILSON-SMITH	KEVIN R	Operations Manager	CIMAS Medical Aid Society	MRS J
MR W F ZIMOWA	W F		Construction Industry Medical Fund	

APPENDIX H

AGENDA

Monday, January 21, 1991

10:30 a.m. - Meeting with Mr. Phillips and Mr. Groppe at Grand Hotel

11:30 a.m. - Depart Grand Hotel for IHB, S.A.

12:00 Noon - Lunch with Alain Faignot and Ruth McKenty at Le' Escargot Restaurant

2:00 p.m. - IHB, S.A. Shareholders Meeting and Board Meeting at IHB offices

4:00 p.m. - Mr. Gamble returns to Hotel

7:00 p.m. - Cocktails and dinner with Joel du Boisvouray, Faignot, McKenty and Groppe

Tuesday, January 22, 1991

10:00 a.m. - Depart Grand Hotel for AXA

10:30 a.m. - Business meeting and lunch with Mr. Brossier and senior management of AXA at their main office on Avenue Mantignon

3:00 p.m. - Mr. Gamble returns to Hotel

7:00 p.m. - Cocktails and dinner with Mr. DeLothe, President, and Jean-Luc Wolff of SECA brokerage company

Wednesday, January 23, 1991

No scheduled meetings for Mr. Gamble

Note: Mr. Teulade was not able to meet for dinner with Mr. Gamble.

GROUP HOSPITALIZATION AND MEDICAL SERVICES, INC.

TRAVEL EXPENSE REPORT

CHECK NO

(SEE REVERSE SIDE FOR INSTRUCTIONS)

NAME OF EMPLOYEE *(Please Print)*	DSU	PURPOSE OF TRIP	LOCATION
J. P. Gamble	AA10	International Health Benefits S.A. - January 20-25, 1991	Paris, France

TOTAL EXPENSES

DATE	1/20/91	1/21/91	1/22/91	1/23/91				TOTAL EXPENSES
MEALS and BEVERAGES								
TAXI, LIMO OR BUS	190 66							190 66
ENTERTAINMENT (Explain below)								
TRANSPORTATION AIR ☐ TRAIL ( )	2087 80							2087 80
HOTEL/MOTEL	2015 95							2015 95
REGISTRATION FEE								
AUTO (Number of Miles ___)								
OTHER (EXPLAIN BELOW)	3088 53							3088 53
TOTAL	7382 94							7382 94

EXPENSES PREPAID OR CHARGED TO GHMSI

ORGANIZATION TO WHOM CHECK WAS/WILL BE DRAWN	INDICATE PREPAID (P) OR CHARGED (C)	GENERAL DESCRIPTION OF ITEM(S)	AMOUNT
American Airlines	C	Airfare	5168 00

EXPLANATION OF ENTERTAINMENT AND OTHER EXPENSES

All items reported as entertainment must be described below with date(s), person(s) entertained and his/her organization.

All items reported above as "other" must be described below

Other: $3080.20 - Corporate Account

8.33 - Tips

TOTAL EXPENSES PREPAID OR CHARGED 5168 00

We certify that these expenses were incurred in accordance with GHMSI travel policy guidelines and that they represent prudent, reasonable and necessary expenses incurred in the performance of Company business.

SUBMITTED BY J. P. Gamble DATE 2/21/91

DSU TO BE CHARGED AA10

LINE OF BUSINESS IMPACTED All

APPROVED BY J. P. Gamble DATE 2/21/91

J. P. Gamble 2/21/91
APPROVED FOR PAYMENT DATE

SETTLEMENT

TOTAL EXPENSES	7382 94
LESS PERSONAL EXPENSES	— —
BALANCE	7382 94
LESS TOTAL EXP PREPAID OR CHARGED TO GHMSI	5168 00
BALANCE	2214 94
LESS TRAVEL ADVANCE	— —
NET DUE EMPLOYEE OR (GHMSI)	2214 94

If GHMSI is to be reimbursed by another organization for all or a portion of this expense specify the organization and the amount. (See instruction "9" on back.)

GHMSI TO BE REIMBURSED BY AMOUNT

GROUP HOSPITALIZATION AND MEDICAL SERVICES, INC.

REQUEST FOR TRAVEL ADVANCE

CHECK NO

(See Reverse Side for Instructions)

AMOUNT REQUESTED

SUBMITTED BY (Print)

EMPLOYEE NO. AND DSU

SIGNATURE

DATE OF REQUEST

CHECK NEEDED BY (DATE)

DATE(S) OF TRAVEL
Departure Date — Return Date

APPROVED BY

(DATE(S) OF TRAVEL MUST BE INCLUDED)

Request with appropriate approval and with Estimated Travel Authorization Form must be received by Cost and Budgeting at least five working days prior to departure.

BLUE CROSS AND BLUE SHIELD
PORTUGAL SITE INSPECTION
JUNE 12 - 15, 1989

June 12

Linda Hester and Dave Restel depart Washington National at 4:15PM for JFK. Marcia will meet in JFK and all travel together to Lisbon and Faro.

June 13

Arrival in Faro Airport at 10:20 A.M. Transfer to Hotel Vilamoura Marinotel (approximately 15 minutes from airport). There will be time to freshen up before a thorough site inspection of the resort facility. In addition to general sight seeing in the Algarve (including beach areas and golf courses), the afternoon will include a visit to the Quinta da Pomona, which is located in an old Algarvian farm. This is a possible site for a theme dinner event. An early dinner will be planned at one of the dine around restaurant selections.

June 14

Departure from the Vilamoura Marinotel will be at 6:30 A.M. In the interest of time, we will fly from Faro to Lisbon, arriving in Lisbon by 8:00 A.M. Transfer to the Hotel Palacio and complete site inspection of the hotel facility. Late morning we will travel to a Posada where we are suggesting Blue Cross Blue Shield participants have lunch on their day of transfer from the Algarve to Lisbon. In addition we will have a basic guided tour of Lisbon. This evening's dinner will be at the Hotel do Guincho, the site suggested for the Blue Cross Blue Shield awards banquet.

June 15

A leisurely breakfast is planned for the purpose of general discussion on the Portugal experience.

Linda and Marcia depart late morning for the airport. Dave departs shortly after noon.

Rec'd in Cost & Budgeting JUL 03 1989

BLUE CROSS AND BLUE SHIELD OF THE NATIONAL CAPITAL AREA

TRAVEL EXPENSE REPORT

3910

CHECK NO.

(SEE REVERSE SIDE FOR INSTRUCTIONS)

NAME OF EMPLOYEE (Please Print)	EMPLOYEE DSU	PURPOSE OF TRIP	LOCATION
David H. Kestel	BB10	Site inspection 1991 Mkt. Sales Awards and Re-insurance agreement for NCRe	Lisbon, Portugal & London, England

Rec'd in Cost & Budgeting JUL 03 1989

TOTAL EXPENSES

DATE	6/12/89	6/13/89	6/14/89	6/15/89	6/16/89				TOTAL EXPENSES
MEALS and BEVERAGES		131 74							131 74
TAXI, LIMO OR BUS			8 00	50 00	50 00				108 00
ENTERTAINMENT (Explain below)									
TRANSPORTATION: AIR XX RAIL ( )	4453 90								4453 90
HOTEL/MOTEL	354 11								354 11
REGISTRATION FEE									
AUTO (Number of Miles____)									
OTHER (EXPLAIN BELOW)	124 84								124 84
TOTAL	4932 85	131 74	8 00	50 00	50 00				5172 59

EXPENSES PREPAID OR CHARGED TO BCBSNCA

ORGANIZATION TO WHOM CHECK WAS/WILL BE DRAWN	INDICATE PREPAID (P) OR CHARGED (C)	GENERAL DESCRIPTION OF ITEM(S)	AMOUNT
Lovejoy - Tiffany	C	airfare	1576 90
Amer. Airlines (JPG's #)	C	airfare (international flight)	2557 00
Amer. Airlines (DHK's #)	C	airfare (domestic)	320 00

EXPLANATION OF ENTERTAINMENT & OTHER EXPENSES

TOTAL EXPENSES PREPAID OR CHARGED 4453 90

All items reported as entertainment must be described below with date(s), persons entertained and their organization.

All items reported above as "other" must be described below.

OTHER - $2.00 airport parking; $20.00 tips; $102.84 telephone

* Hotel - Hotel in Lisbon paid by Lovejoy - Tiffany

7230 L032 AHRN 2928.58
1311 2224.87
7230 L032 AHRN 1576.90

2325

EIGHUP HOSPITALIZATION JUL 11 1989

COPY SENT TO CFA JUL 11 1989

We certify that these expenses were incurred in accordance with BCBSNCA travel policy guidelines and that they represent prudent, reasonable and necessary expenses incurred in the performance of Company business.

SUBMITTED BY: _____ DATE 6/29/89

DSU TO BE CHARGED: L032 charge $2928.58; NCRe charge $2224.87

LINE OF BUSINESS IMPACTED non-FEP
(i.e. All DSU Business, NON-FEP, Medicare A, FEP Operations Center, FEP-Institutional etc.)

APPROVED BY: _____ DATE _____

APPROVED FOR PAYMENT _____ DATE

SETTLEMENT

TOTAL EXPENSES	5172 59
LESS PERSONAL EXPENSES	19 14
BALANCE	5153 45
LESS TOTAL EXP. PREPAID OR CHARGED TO BCBSNCA	4453 90
BALANCE	699 55
LESS TRAVEL ADVANCE	-0-
NET DUE EMPLOYEE OR (BCBSNCA)	699 55

If BCBSNCA is to be reimbursed by another organization for all or a portion of this expense, specify the organization and the amount (See instruction "I" on back.)

GHMSI 24C1 00206

BCBSNCA TO BE REIMBURSED BY _____ AMOUNT _____

A P P E N D I X J

1987-1992 TRAVEL EXPENSES FOR J. P. GAMBLE - R. GROPPE - D. H. KESTEL

The following is an outline of Messrs. Gamble's, Groppe's and Kestel's travel expenses for 1987 to 1992, followed by their travel schedule for the same time frame. The Corporate Account totals reflect any charges that would be considered first class and, according to GHMSI, were kept separate from general travel costs. These totals represent those displayed on TERs and do not reflect reimbursements made to the Plan by these individuals for personal expenses. Data was obtained from GHMSI travel vouchers and Mr. Gamble's personal calendar.

J. P. GAMBLE'S TRAVEL EXPENSES

Year	Corporate Account Totals	Total Cost of Travel
1987	$ 232.00	$ 3,441.73
1988	40,232.06	99,702.64
1989	38,889.51	82,297.15
1990	43,442.21	104,415.75
1991	44,794.00	102,872.43
1992 (Jan-July)	25,541.46	54,278.08
TOTALS	$193,131.24	$447,007.78

R. GROPPE'S TRAVEL EXPENSES

Year	Total Cost of Travel
1988	57,197.00
1989	83,698.00
1990	56,997.00
1991	86,951.00
1992 (Jan-Nov)	46,544.00
TOTALS	$331,387.00

D. H. KESTEL'S TRAVEL EXPENSES

Year	Total Cost of Travel
1987	$ 1,205.00
1988	19,673.00
1989	41,190.00
1990	40,450.00
1991	64,896.00
1992 (Jan-June)	58,394.00
TOTALS	$225,808.00

JOSEPH P. GAMBLE'S TRAVEL
(1987-1992)

All travel approved by Gamble.
Used both General & Corporate Accounts.

Date	Destination	Corporate Account	Total Cost Of Trip
1987			
Dec.13-15	Denver, CO; Chicago, IL	$ 232.00	$ 1,817.73
Dec. 2-5	La Quinta, CA	-0-	1,624.00
	TOTALS 1987	$ 232.00	$ 3,441.73
1988			
Jan.17-21	Newport Beach & Laguna Beach,CA	$ 2,208.00	$ 5,626.50
Feb.3-5	Atlanta, GA	60.00	1,475.00
Feb.14-20	Kingston, Jamaica; Bridgetown, Barbados; Miami, FL; Nassau, Bahamas	554.00	3,464.39
Mar.1	Pittsburgh, PA	-0-	205.50
Mar.7-8	Chicago, IL	-0-	-0-
Mar.9-13	Phoenix, AZ	-0-	-0-
Mar.21-23	Mexico City, Mexico	432.40	1,922.10
Apr.3-8	London	3,293.00	7,545.50
Apr.20-22	Chicago, IL	290.00	1,440.46
May 2	Pittsburgh, PA	-0-	222.00
May 11-27	Killarney,Ireland; London;Paris	9,854.77	14,093.17
May 31-Jun. 2	Kingston, Jamaica	348.00	1,129.40
Jun.5-12	Hamilton, Bermuda	787.00	7,210.43
Jun.13	Chicago, IL	306.00	941.00
Jun.16	New York, NY	-0-	214.00
Jun.19-23	Palm Desert, CA	2,200.00	801.34

Jun.28-Jul.10	Hilton Head, SC (Vacation)	-0-	-0-
Jul.27-28	Chicago, IL	-0-	-0-
Jul.24-27	London; Dublin	4,310.00	7,213.94
Aug.7-20	Alaska Tour Cruise	-0-	-0-
Aug.20-27	Vancouver, Canada	1,067.20	5,064.51
Sep.7	Chicago, IL	306.00	939.00
Sep.12-Oct.4	Beijing, China; Hawaii; Kyoto, Japan; Tokyo, Japan; Hong Kong; Singapore; London	10,836.79	25,723.97
Oct.7	Miami, FL	26.00	734.00
Oct.19-21	Schaumburg, IL	316.00	1,566.07
Oct.23-25	Dallas, TX	452.00	1,688.69
Nov.16-18	Chicago, IL	468.69	1,988.07
Nov.29-Dec.1	Palm Springs, CA	-0-	-0-
Dec.4-9	Paris; Dublin	1,378.00	5,096.77
Dec.10-12	Nassau, Bahamas	698.21	1,615.13
Dec.13-14	Chicago, IL	-0-	-0-
Dec.18-19	Kingston, Jamaica	-0-	1,363.70
Dec.21	Durham, NC	40.00	418.00
	TOTALS 1988	$ 40,232.06	$ 99,702.64
1989			
Jan.19	Charleston, WV (BCBSWVA Board Mtg)	$ 20.00	$ 280.00
Jan.23-29	Tokyo, Japan	-0-	311.00
Feb.1-3	Kingston, Jamaica	-0-	1,248.08
Feb.7-10	Dallas, TX	432.00	1,838.18
Feb.14-16	Barbados; Puerto Rico	376.00	1,945.36

Feb.22-Mar.3	London; Paris; Harara, Zimbabwe	2,740.78	7,903.08
Mar.9	Miami, FL	-0-	845.00
Mar.15	Chicago, IL	316.00	971.00
Mar.29-30	Chicago, IL	316.00	1,350.70
Apr.12-16	Phoenix, AZ	1,772.96	4,485.38
Apr.20	Charleston, WV	-0-	246.00
Apr.23-29	Hamilton, Bermuda	60.00	1,035.00
May 8-10	Caracas, Venezuela	546.00	2,227.48
May 19	Miami, FL	396.00	1,245.00
May 21-25	Paris	9,283.00	11,221.23
Jun.12-13	Dallas, TX	399.70	1,794.14
Jun.27	New York, NY	-0-	198.00
Jun.28	Newport, RI	40.00	410.00
Jul.11	Charleston, WV	-0-	348.00
Jul.17-18	Chicago, IL	-0-	-0-
Aug.3-7	Vacation - Hilton Head, SC	-0-	-0-
Aug.8	New York, NY	-0-	257.00
Aug.13-19	London; Dublin; Paris	11,342.38	14,134.91
Sep.18	New York, NY	-0-	218.00
Sep.19-20	Chicago, IL	268.69	1,348.41
Sep.27	New York, NY	-0-	253.75
Oct.11-13	Charleston, WV	-0-	271.50
Oct.17-25	Singapore; Sydney, Australia	3,704.00	11,218.21
Oct.29-31	Irving, TX	432.00	1,778.40
Nov.10	Miami, FL	100.00	825.00
Nov.15-21	Hilton Head, SC (Vacation)	-0-	-0-
Nov.29	Charleston, WV	-0-	255.00

Dec.4-5	Rosemont, IL	316.00	1,329.80
Dec.6-8	La Quinta, CA	552.00	2,594.64
Dec.12-14	Dublin	5,476.00	7,909.90
	TOTALS 1989	$ 38,889.51	$ 82,297.15
1990			
Jan.25-26	Kingston, Jamaica	$ 274.00	$ 1,312.43
Mar.2	Miami, FL	130.00	742.00
Mar.4-9	Dublin; Paris	3,984.59	7,428.77
Mar.19	Toronto, Canada	54.00	476.71
Mar.22-26	Monte Carlo, Monaco	-0-	539.42
Mar.27-30	Chicago, IL; Jamaica	179.90	622.00
Apr.19	Charleston, WV	25.00	314.00
Apr.24-May 2	London; Noordwijk, Netherlands	2,912.00	14,814.07
May 7-8	Kingston, Jamaica	24.00	991.24
Jun.21	New York, NY	-0-	482.00
Jun.24-28	London	3,486.00	8,077.46
Jul.16-17	Chicago, IL	-0-	-0-
Jul.19	Charleston, WV	25.00	326.00
Jul.23	New York, NY	-0-	244.75
Jul.27	Cleveland, OH	50.00	410.00
Aug.15	Boston, MA	50.00	559.25
Aug.19-Sep.8	Hong Kong; Singapore; Sydney	11,644.82	28,839.07
Sep.20-28	Dublin; Deauville, France; Munich; West Germany	10,909.43	16,003.08
Oct.29-31	Bridgetown, Barbados	446.00	2,288.95
Nov.2	Miami, FL	100.00	859.00
Nov.11-13	Dublin	4,402.00	6,546.35

Nov.14-16	Chicago, IL	1,375.47	3,822.08
Dec.2-7	Paris; Munich	3,370.00	8,717.12
Dec.10-11	Chicago, IL	-0-	-0-
	TOTALS 1990	$ 43,442.21	$104,415.75
1991			
Jan.20-23	Paris, France	$ 3,080.20	$ 7,382.94
Jan.24-25	Kingston, Jamaica	245.00	1,191.00
Mar.19-22	London	4,294.00	7,815.72
Apr.14-18	Queretano, Mexico	279.00	1,103.50
Apr.26	Miami, FL	152.00	884.00
May 9-11	Phoeniz, AZ	173.00	1,426.76
May 13-19	Faro, Portugal	9,813.00	15,894.92
Jun.11	Miami, FL	160.00	889.00
Jun.17-21	Dublin; Paris	3,722.00	6,703.20
Jun.25-27	Minneapolis, MN	378.00	1,359.57
Jul.1	Washington, D.C.	120.00	941.42
Jul.14-16	Paris	-0-	6,567.38
Jul.22-23	Oakbrook Terrace, IL	-0-	-0-
Jul,30	Boston, MA	60.00	635.25
Aug.13-14	Reading, England	4,498.00	7,272.23
Aug.26-27	San Juan, Puerto Rico; Bridgetown, Barbados	909.00	2,474.28
Sep.3-6	Dublin	3,836.00	7,671.78
Sep.20	Maimi, FL	160.00	929.00
Sep.23-28	Toyko, Japan; Singapore	2,640.00	7,680.17
Oct.21-Nov.1	Paris; London	4,068.80	11,343.27
Nov.13	Waterloo, Canada	66.00	607.55

Nov.19-20	Atlanta, GA	1,320.00	2,848.87
Dec.4-6	Kingston, Jamaica	394.00	1,201.00
Dec.8-10	Dublin	4,074.00	6,741.17
Dec.16-17	Oakbrook Terrace, IL	352.00	1,308.45
	TOTALS 1991	$ 44,794.00	$102,872.43
1992			
Jan.21-23	Dublin; Paris	$ 3,718.00	$ 6,707.70
Jan.26-Feb.16	Lanai City, HI	-0-	276.00
Mar. 2-3	Bridgetown, Barbados	281.00	2,151.46
Mar.6	Miami, FL	208.00	1,156.00
Mar.12-17	Naples, FL	843.72	1,962.00
Mar.22-25	Dallas, TX; Salt Lake City, UT	375.00	2,728.50
Apr.12-14	Dublin; London	4,074.00	7,046.28
Apr.22-24	Mexico City, Mexico	462.00	1,662.69
Apr.26-May 2	Monterey, CA	700.00	3,434.84
May 29-Jun.6	Isle of Jersey, U.K.	11,047.84	18,257.30
Jun.15-18	Jackson Hole,WY; SaltLakeCty,UT	178.00	1,346.00
Jul.19-21	Paris	3,653.90	7,549.31
	TOTALS 1992	$ 25,541.46	$ 54,278.08

J. P. GAMBLE'S TRAVEL EXPENSES

Year	Corporate Account Totals	Total Cost of Travel
1987	$ 232.00	$ 3,441.73
1988	40,232.06	99,702.64
1989	38,889.51	82,297.15
1990	43,442.21	104,415.75
1991	44,794.00	102,872.43
1992 (Jan-July)	25,541.46	54,278.08
TOTALS	$193,131.24	$447,007.78

RICHARD GROPPE'S TRAVEL
(1988-1992)

All travel approved by Groppe. Used both General and Corporate Accounts. Figures not segregated.

Date	Destination	Total Cost Of Trip
1988		
Jan.17-23	London, England (Supersonic)	$ 6,735.00
Feb.14-19	Jamaica; Barbados	2,475.00
Mar.21-24	Mexico City (1st & Coash Class)	2,298.00
Mar.29	New York	230.00
Apr.11-15	Caracas, Venezuela (1st Class)	2,871.00
May 19-27	London; Bristol; Paris Supersonic, Business & Coash Class)	6,969.00
Jul.27-30	Dublin, Ireland; Bristol, England (Supersonic & Business Class/Airfare $4191)	6,837.00
Aug.8	Cleveland, OH	310.00
Aug.10-12	Caracas, Venezuela (1st Class)	1,641.00
Aug.21-27	Vancouver, Canada (W/Wife)	4,122.00
Sep.17-Oct.4	Tokyo; Bejing; Hong Kong; Singapore (Business & 1st Class)	11,372.00
Oct.23-29	Dublin; London (Supersonic & Business Class/ Airfare-$4571)	6,285.00
Dec.4-10	Paris; Dublin (Supersonic, 1st, & Business Class/Airfare-$3593)	5,052.00
	TOTAL 1988	$ 57,197.00
1989		
Jan.22-27	Paris; London (Supersonic, 1st & Business Class)	$ 5,088.00
Feb.15-18	Honolulu, HI (1st Class)	3,305.00
Feb.21-25	London; Dublin (Supersonic, 1st & Business Class/Airfare-$4852)	7,026.00

Mar.28-Apr.1	London; Guernsey (Supersonic, 1st & Business Class/Airfare-$5908)	7,170.00
Apr.17-22	Mexico; Panama (1st Class)	$ 3,130.00
May 21-27	Paris; Amsterdam (Supersonic, 1st & Business Class)	5,852.00
Jun.25-Jul.1	Paris; London (Supersonic, 1st & Business Class)	7,770.00
Jul.17-27	Singapore; Hong Kong (1st Class)	8,366.00
Aug.6-8	Ft. Wayne, IN	820.00
Aug.13-18	London; Guernsey; Dublin; Bristol (Supersonic & Business Class/Airfare-$4993)	6,870.00
Sep.27-28	New York, NY	720.00
Oct.9-22	Dublin; London; Hong Kong; Singapore (Supersonic, 1st, & Business Class)	12,214.00
Nov.26-Dec.2	Paris; Dublin; London	$ 6,463.00
Dec.11-15	Dublin; London (Supersonic, 1st, Business Class)	8,904.00
	TOTAL 1989	$ 83,698.00
1990		
Feb.5-10	Mexico City, Monterey, Mexico (1st Class)	$ 2,374.00
Feb.15	New York, NY	$ 265.00
Mar.4-10	Paris; Dublin (Supersonic & Business Class)	7,395.00
Mar.19-23	Venezuela; Barbados (1st Class)	$ 3,393.00
Apr.16-17	Miami, FL	$ 1,223.00
Apr.22-28	Guernsey; London (Supersonic & 1st Class)	7,953.00
Jun.11-12	St. Thomas, USVI (1st & Coach Class)	1,306.00
Jun.24-30	London; Brussels; Paris (1st & Coach Class)	7,979.00
Jul.15-20	Paris	6,220.00
Sep.5	Palm Beach, FL (1st Class)	642.00

Sep.19-29	London; Paris; Deauville; Munich Supersonic, 1st, Business Class)	9,247.00
Oct.28-30	Barbados (1st Class)	1,999.00
Dec.2-8	Munich; Paris (Supersonic, 1st, Business, & Coach Class)	7,001.00
	TOTAL 1990	$ 56,997.00
1991		
Feb.20-26	Paris (Part of ticket charged to Groppe's American Express)	$ 6,978.00
Feb.15-23	Singapore (1st Class)	8,442.00
Mar.17-23	London; Dublin (Supersonic, 1st & Business)	9,499.00
Apr.9-19	Brussels; Mexico Supersonic, 1st & Business Class)	$ 8,420.00
May 13-18	London; Paris (Supersonic, 1st & Business)	$ 8,866.00
Jun.14-22	Paris, Dublin Supersonic, 1st, Business & Coach Class)	7,988.00
Jul.7-16	Paris; Lyon; Montpelier (Supersonic & Coach)	5,557.00
Sep.2-7	Dublin & Paris (1st & Business Class)	7,797.00
Sep.23-28	Singapore (1st Class)	$ 7,342.00
Oct.20-26	Paris; Lyons (Supersonic, 1st, & Business)	4,804.00
Nov.17-22	Monterey, Mexico; Santo Domingo (1st & Business Class)	2,916.00
Nov. 26	Hilton Head, SC	924.00
Dec.2-6	Paris; Munich Supersonic, 1st & Business Class)	7,418.00
	TOTAL 1991	$ 86,951.00
1992		
Jan.10-24	Paris; Singapore; Jakarta (1st & Business)	$ 10,841.00
Mar.3-6	London; Bristol (Supersonic, 1st & Business)	7,609.00
Apr.12-15	Dublin; London; Folkestone (Supersonic & Business Class)	8,272.00
Apr.21-25	Mexico City (1st Class)	3,263.00

May 18-23	USVI & San Juan, Puerto Rico (1st Class)	2,587.00
Jun.17-20	Paris (Supersonic, Business, & Coach)	6,598.00
Nov.11-17	Dublin; Paris; Mexico (Supersonic, 1st, & Business Class)	7,374.00
	TOTAL 1992	$ 46,544.00

R. GROPPE'S TRAVEL EXPENSES

Year	Total Cost of Travel
1988	57,197.00
1989	83,698.00
1990	56,997.00
1991	86,951.00
1992 (Jan-Nov)	46,544.00
TOTALS	$331,387.00

DAVID KESTEL'S TRAVEL
(1987-1992)

All travel approved by Kestel. Used both General and Corporate Accounts. Figures not segregated.

Date	Destination	Total Cost Of Trip
1987		
Dec.6-12	Barbados (1st Class)	$ 1,205.00
	TOTAL 1987	$ 1,205.00
1988		
Jan.5-6	New York, NY	$ 374.00
Mar.7-8	Denver, CO	436.00
Mar.18-22	Bermuda (Site Inspection For 88 GHMSI Marketing Sales Award Trip)	943.00
Apr.20	Toledo, OH (1st Class Available Only)	755.00
May 11-19	Killarney,Ireland (BCBSNCA Sales Conference)	11,668.00
May 23-24	Miami, FL (FF Upgrade to 1st)	592.00
Jul.18-19	Denver, CO	839.00
Aug.23-26	Chicago, IL (FF Upgrade)	1,148.00
Aug.31-Sep.1	Columbus, OH	494.00
Sep.28-29	Miami, FL	633.00
Oct.13-15	Hilton Head, SC (Golf-"Goodwill" Trip)	1,100.00
Oct.18-20	Bermuda (Site Inspection For 89 Sales Conf.)	691.00
	TOTAL 1988	$ 19,673.00
1989		
Jan.25-26	Miami, FL (FF to 1st Class)	$ 764.00
Feb.14-16	Barbados (1st Class)	2,120.00
Feb.22-25	London (Supersonic $5,430/Coach $1,923)	7,062.00
Feb.27-Mar. 1	Naples, FL (Site Inspection for 89 Sales Awards)	945.00

Apr.23-27	Bermuda (88 Sales Incentive)	1,061.00
Jun.12-16	Portugal; London (Site Inspection for 91 Marketing Sales Trip)	5,172.00
Jul.9-12	Boulder, CO	1,702.00
Jul.18-20	London (1st Class)	6,742.00
Jul.21-23	Chicago, IL	627.00
Jul.26	Charleston, WV	300.00
Aug.13-18	London; Paris; Dublin (business class)	7,300.00
Nov.3	Charleston, WV (1st Class)	308.00
Nov.28-Dec.1	London; Dublin (1st Class)	7,087.00
	TOTAL 1989	$ 41,190.00
1990		
Jan.31-Feb.2	Monterey, CA (Site Inspection for 92 Sales Awards/Does Not Include Airfare)	$ 349.00
Mar.3-6	Dublin (1st & Coach)	6,448.00
Mar.13-26	Naples, Orlando, FL	1,911.00
May 8-10	Barbados (1st Class)	1,907.00
Jun.11-12	Miami, FL	866.00
Jun.24-26	London	7,290.00
Jul.11-13	Freeport, ME	237.00
Sep.19-24	Dublin (Supersonic)	10,095.00
Oct.29-31	Bridgetown, Barbados (1st Class)	2,273.00
Nov.11-13	Dublin (Supersonic)	6,779.00
Nov.27-29	Dallas, TX; Chicago, IL (1st Class)	2,295.00
	TOTAL 1990	$ 40,450.00
1991		
Jan.6-8	Dallas, TX (1st Class)	$ 1,911.00
Jan.17-21	Bermuda (1st Class)	1,302.00

Mar.6-8	Minneapolis, MN (1st Class)	1,995.00
Mar.24-27	Phoenix, AZ (1st Class)	2,901.00
Apr.8-11	Salt Lake City, UT; San Francisco, CA; Dallas, TX	4,282.00
Apr.21-24	London (Bank of Ireland) (Supersonic)	8,732.00
May 12-19	Portugal (91 Sales Incentive Trip/$362 Golf)	1,359.00
May 21-23	Ft. Worth, TX (1st Class)	1,865.00
Jun.11	Indianapolis, IN (1st Class)	716.00
Jun.19-28	Switzerland; Austria; Hungary (1st Class, For Site Inspection of 93 Marketing Sales Award Trip)	1,948.00
Jun.17-19	Dublin (Supersonic)	4,859.00
Aug.15-19	Salt Lake City, UT; Jackson Hole, WY (1st Class/Golf $684)	2,636.00
Sep.3-6	Dublin (Supersonic)	7,437.00
Sep.24	Salt Lake City, UT (1st & Coach Class)	1,114.00
Oct.2	Indianapolis, IN (1st Class)	678.00
Oct.8-10	Monterey, San Francisco, CA (Site Inspection for 92 Sales Conference; $668 promotional items purchased for contestants; Some 1st Class)	3,129.00
Oct.27-30	London; Dublin (Supersonic)	8,232.00
Dec.4-12	Salt Lake City, UT; San Francisco, CA (1st Class)	1,614.00
Dec.8-10	Dublin (Supersonic/Not Signed)	7,384.00
Dec.19	Indianapolis, IN (1st Class)	802.00
	TOTAL 1991	$ 64,896.00

1992		
Jan.15-16	Salt Lake City, UT (1st Class)	$ 1,520.00
Jan.17-20	Bermuda (No Attachments)	803.00

Jan.25-Feb.1	Lanai City, HI (B'nai B'rith Executive Seminar/Not Signed/1st & Coach/Wife)	8,733.00
Feb.2-5	Hawaii (Site Inspection for 94 Marketing Sales Conference)	531.00
Feb.10-13	Dallas, TX (1st Class)	2,285.00
Mar.2-3	Barbados (1st Class)	1,996.00
Mar.23-26	Dallas, TX; Salt Lake City, UT (1st Class)	3,830.00
Apr.5-8	Tucson, AZ (Life Affiliates Conference/ 1st Class/Room $635/Wife)	4,302.00
Apr.12-14	Dublin (Supersonic)	7,313.00
Apr.26-May 3	Monterey, CA (92 Sales Incentive/Not Signed/1st Class/Wife)	4,474.00
May 7-8	Salt Lake City, UT (1st Class)	1,446.00
May 19-21	Dallas, Ft. Worth, TX (1st Class)	1,375.00
Jun.15-18	Jackson Hole, WY; Salt Lake City, UT (1st Class)	1,958.00
Jun.29-30	Newark, NJ	164.00
Jul.5-8	Dublin (Supersonic)	7,620.00
Aug.11-13	Dallas, TX (1st Class)	991.00
Sep.10-11	Dallas, TX (1st Class, Sale of First Continental Life & Accident)	850.00
Sep.27-Oct.2	Dublin (Business Class)	6,939.00
Oct.13-15	Minneapolis, MN	1,264.00
	TOTAL 1992	$ 58,394.00

D. H. KESTEL'S TRAVEL EXPENSES

Year	Total Cost of Travel
1987	$ 1,205.00
1988	19,673.00
1989	41,190.00
1990	40,450.00
1991	64,896.00
1992 (Jan-June)	58,394.00
TOTALS	$225,808.00

APPENDIX K

1989-1992 BCBSNCA AND GHMSI CORPORATE ACCOUNT EXPENSES

(As provided by GHMSI.)

BCBSNCA Corporate Account

1989-1992:		
	Total for Other Expenses	$145,419.20
	Total for 1st Class Premiums	3,972.61
	TOTAL	$149,391.81

Year by Year:

1989:	Other Expenses	$11,076.44
	1st Class Premiums	2,430.61
	TOTAL	$13,507.05
1990:	Other Expenses	$65,647.86
	1st Class Premiums	585.00
	TOTAL	$66,232.86
1991:	Other Expenses	$55,105.30
	1st Class Premiums	957.00
	TOTAL	$56,062.30
1992:	Other Expenses	$13,589.60
	1st Class Premiums (January-June)	0.00
	TOTAL	$13,589.60

GHMSI Corporate Account

1988-1992:		
	Total for Other Expenses	$352,677.00
	Total for 1st Class Premiums	475,906.64
	TOTAL	$828,583.64

Year by Year:

1988:	Other Expenses	$118,459.38
	1st Class Premiums	70,121.16
	TOTAL	$188,580.54
1989:	Other Expenses	$ 80,710.73
	1st Class Premiums	97,294.45
	TOTAL	$178,005.18
1990:	Other Expenses	$ 62,533.87
	1st Class Premiums	114,094.81
	TOTAL	$176,628.68
1991:	Other Expenses	$ 85,070.38
	1st Class Premiums	156,406.42
	TOTAL	$241,476.80
1992:	Other Expenses	$ 5,902.64
	1st Class Premiums (January-June)	37,989.80
	TOTAL	$ 43,892.44

APPENDIX L

D. H. KESTEL'S ITEMIZED LOCAL GOLF CHARGES SUBMITTED AS LOCAL BUSINESS EXPENSE - 1988-1992

1988

3/12	Golf - Vincent, Board, Trust	$ 178.50
4/19	Golf - Avenel - Mont. City-Stein, Hill, Pace	20.00
5/2	Golf tips	10.00
5/20	Golf - Hart & Assoc.	32.00
5/19-22	Golf - tourn. 6 people	467.00
7/15	Golf - Hardie	33.50
7/17	Golf - Rempe - Manor Care	
9/8	Golf - Avenel Heritage Found.	5.00
9/9	Golf - Giuliani Moore Cadillac	25.00
9/10	Golf balls	7.35
9/22-24	Golf tourn. - Kahl	497.00
9/25	Golf - Rempe - Manor Care	28.50
9/27	Golf Avenel Boeing Aircraft	15.00
10/5	Golf - Becker, Brian	30.00
10/6	Golf - Avenel	5.00
10/23	Golf - Gatewood	25.00
10/30	Golf - Hardie	17.00
10/7	Golf - A.J. Ellis	37.00
10/8	Golf Rempe Manor Care	35.00
10/22	Golf - Hardie - Golf	25.50
11/20	Golf - Pollack	28.00
12/3-4	Golf - J. Baron	180.00
11/15	Golf - Moore Cadillac	23.50
	SUBTOTAL	$1,863.30

1989

1/20	Golf	81.90
3/16	Golf and balls - Potomac Systems	284.50
3/18	Golf NCIA tourn.	196.90
4/14	Golf - McLeitsch, Crater	30.00
5/9	Golf - Protocol	224.50
5/18-21	Golf - G. Brown	567.00
8/19	Golf - Hardie	25.00
9/26	Golf - N. Crawley - Allied Irish	80.00
10/3	Golf - Congress Lake	5.50
10/11	Golf - Avenel, Hendren, Corbet	10.00
10/12	Golf - Avenel, Wood, Riley	17.00
10/15	Golf - Hart, Broker	25.00
10/1	Golf balls	29.40
	SUBTOTAL	$1,572.30

1990

4/23	Golf outing	100.00
4/25	NCIA Golf	39.80
5/11	Golf balls for seminar	29.40
5/2	Golf balls	29.40
5/29	Golf - Kemper Open	65.00
7/20	Golf	150.00
7/21	Golf	42.50
7/27	Golf tourn. & shop	168.00
7/18	Golf	29.40
7/21	Golf - R. Gatewood	9.00
8/19	Golf - Giuliani, Moore Cadillac	30.00
9/7	Golf - McCorkendale, USA Today	40.00
8/28	Jr. Golf	32.65
9/5	Golf - A.J. Ellis	51.38
9/6	Golf - R. Bennett	35.50
9/8	Golf - Rogers Broker	39.38
10/3	Golf - R. Hart, Hodge Hart, Inc.	30.00
10/24	Golf tourn. Caddy Grand	75.00
11/20	Golf - H. Cain, Giuliani	33.50
	SUBTOTAL	$1,029.91

1991

3/16	Golf tourn. - Riley, Protocol	215.00
4/12	Golf - J. Dempsey, S. Socaris	85.00
4/16	Golf - J. Bonnett	120.00
5/9	Golf - Billy Dean PSI	117.85
5/25	Golf - Cadwell Ulster Bank	158.85
5/28	Golf - Kemper Am.	30.00
5/29	Golf - Kemper Pro.	30.00
7/3	Golf - Dempsey - Burning Tree caddy/tip	25.00
7/14	Golf - Hart of Hodge Hart	30.00
7/16	Golf - Signet Bank, et al.	447.00
7/20	Golf - Rempe Manor Care	25.00
7/31	Golf - Burke, Schliefer, Gamble	122.50
8/14	Golf - S. Arnold	133.50
8/22	Golf - Belinki Group	548.00
10/5	Golf & gifts	184.95
12/24	Golf balls and gifts	146.48
12/29	Golf balls for gifts	182.70
	SUBTOTAL	$2,601.83

1992

2/8	Golf balls	30.45
2/17	Golf - Rempe et al.	143.50
2/22	Golf - Rempe	50.00
3/8	Golf - Rempe, J. Hardie - Broker	40.00
3/14	Golf tourn. - G. Brown BCBS	190.00
3/15	Golf - J. Rempe	45.00
3/21	Golf - J. Rempe - Manor Care	55.00
4/3	Golf balls	30.45
4/10	Golf - J. Rempe, Manor Care	70.00
5/24	Golf - Burning Tree - Riley, Kemper	33.80
5/26	Golf caddy tips	40.00
6/4-5	Golf Burning Tree (caddies, carts, tips)	110.20
6/6	Golf " " " " "	508.00
6/24	Golf Burning Tree, Jim Collins	110.00
7/11	Golf & lunch, Burning Tree	250.00
7/19	Golf Burning Tree - Bullis/Aaronson	187.00
8/2	Golf Burning Tree - Johnson Mason Univ.	25.00
8/8	Golf Burning Tree - McGee Offitt Donovan	108.50
8/18	Golf Burning Tree - Schleifer, Broker, Brown, Miller	290.50
8/20	Golf Burning Tree - Bonnet Manor Care	103.50
9/18	Golf carts	30.50
9/19	Pro shop/carts	28.40
9/22	Golf carts & tourn.	568.14
10/7	Golf Burning Tree - Brown, Belinki	251.61
10/16	Golf Burning Tree - Malone, Biccici of Comm. Life	206.20
	SUBTOTAL	$3,505.75

1988	$ 1,863.30
1989	1,572.30
1990	1,029.91
1991	2,601.83
1992	3,505.75
TOTAL	$ 10,573.09

* * *

APPENDIX M

COST OF SUBSIDIARY/GHMSI SPONSORED EVENTS AND CHARITABLE CONTRIBUTIONS

GHMSI/BCBSNCA

	1988
$ 2,875	Presidential Classroom for Young Americans
$ 10,000	Sponsorship for three Olympic Athletes in return for personal appearances representing the Plan (In addition to sponsoring three athletes, the Plan's employees raised the funds used to meet BCBSNCA's share of BCBS System's sponsorship of the U.S. Olympic Team.)
$200,000	Beautiful Babies: Right From the Start/prenatal education incentive program
$ 2,381	Walt Disney Physical Fitness Films/Final payment of a multi-year program to place films free in local school systems
	1989
$ 3,200	NFL Alumni Charity Golf Classic
$162,819	Drug Free Zone/Drug education and prevention program
	1990
$ 18,500	Beautiful Babies: Right From the Start
$ 1,200	Joe Jacoby Celebrity Golf Tournament
$ 1,500	Breast Cancer Awareness Awards (Columbia Hospital)
$ 1,600	NFL Alumni Charity Golf Classic
$ 3,500	Olympic Fundraising dinner, sponsored by BCBS Association and USOC
	1991
$229,000	Drug Free Zones
$ 6,750	March of Dimes Golf Tournament
$ 3,000	Have a Heart Foundation
$ 10,000	Olympic Fundraising Dinner sponsored by USOC and Congressional Olympic Caucus
$ 500	Marymount University Inaugural Golf Outing, benefiting Marymount University
$ 500	American Cancer Society
$ 210	Patterson & Smith Association (March of Dimes)
$ 300	Wrap (Washington Regional Alcohol Program)
$ 250	Carmody Open - (Gonzaga High School Scholarship Fund)
$ 10,000	Blue Cross and Blue Shield Association (Olympic Dinner)
$ 2,499	Columbia Hospital for Women
$ 500	American Lung Association
$ 200	Community Family Life Services, Inc.
$ 500	Iona House Senior Services

$ 110	The Corp. Against Drug Abuse
$ 1,000	Association of Health Care Administration
$ 200	Christmas in April, Inc.
$ 2,500	D.C. Hospital Association
$ 1,500	Have a Heart Foundation
$ 45,000	Health System Agency Northern Virginia
$ 100	SW Community House Redevelopment
$ 125	Business Incentive (for homeless pregnant women)
$ 240	WBCTC/Leukemia Society Golf
$ 400	Boarder Baby Project
$ 500	American Red Cross
$ 50	DC Department of Recreation & Parks
$ 3,500	NFL Alumni Washington Chapter
$ 89	Peter Longden (Toys for Tots)
$ 500	Marymount University Scholarship Fund
$ 250	Dr. Martin Luther King Jr.
$ 250	CWS/CROP (Christian Comm. for Action Church World Svs.)
$ 100	A.P. Shaw United Method. Church
$ 40,000	GTR Wash Health Planning Council
$ 500	National Council on the Aging
$ 500	Northern Virginia Project Graduation
$ 200	Capital Children's Museum
$ 100	Food & Friends, Inc.
$ 300	National Kidney Foundation
$ 350	Simone J. Pace (The Arlington Hospital Foundation)
$ 100	The Sunshine Foundation
$ 200	Girl Scouts
$ 771	Service America Corp. (D.C. Central Kitchen)
$ 120	Leadership Washington, Inc.
$ 150	Hace/Hispanic American
$ 300	YMCA Partner with Youth
$ 750	D.C. Friends of Ireland
$ 500	Greater Wash Research Center
$ 25	Alexandria Chamber of Commerce
$ 100	Parents United
$ 2,200	American Heart Association
$ 400	DCUA Golf & Tennis Tourn.
$ 300	Cultural Alliance of Greater Washington
$ 50	Impact D.C., Inc.
$ 500	Camp Fantastic
$ 1,500	National Foundation for Depressive
$ 300	Youth Leaders Camp
$ 1,200	Have a Heart Foundation
$ 200	United States Olympic Committee
$ 350	Whitman Walker Clinic
$ 400	Zacchaeus Free Medical Clinic
$ 500	Bread for the City
$ 6,750	March of Dimes
$ 1,100	Howard Univ College of Medicine
$ 100	Georgetown Univ. Golden Apple
$ 200	Davis Mem. Goodwill Indus.
$ 200	D.C. Commission for Women
$ 200	Montgomery Co., Inc. (Safe Kids)

$ 100	AMI of Montgomery Co., Inc.
$ 1,500	USCSFI
$ 50	American Cancer Society
$ 50	Alzheimers Association
$ 25	Veterans Administration Hospital
$ 25	Children's Hospital
$ 25	St. Paul's Lutheran Church
$ 25	Montgomery Hospice Society
$ 25	Jewish Community Center of Southern Maryland
$ 25	Mt. Vernon Hospital Cardiac Rehab.
$ 25	Terlingo Cancer Funds
$ 25	American Lung Association
$ 25	Radiation Department Arlington Hospital
$ 25	Calvary Episcopal Church

1992

$147,000 (estimate)	Drug Free Zones
$ 450	1st Annual Greater Association of Health Underwriters, benefiting the Childrens Hospital and Special Olympics, August 31, 1992
1990-1992	Sponsor with other BCBS Plans of U.S. Olympic Team. BCBSNCA employees raised approximately $37,000, covering BCBSNCA's share of BCBS System's sponsorship as well as $15,000 for sponsorship of three local Olympic athletes.

CAPITALCARE

1988

$ 5,000	Contribution to the U.S. Olympic Committee
$343,000	CapitalCare ran television ads in association with the 1988 Olympics during September and October 1988. Based on the ads. CapitalCare was given some free tickets to the Olympics. CapitalCare sponsored an essay contest in local schools and awarded the tickets to the winner of the contest.

1991

$ 50	Community Family Life Services
$ 30	Wake Forest Cardiac Rehabilitation Program

EMTRUST

1988

$ 1,000	Kemper Open

1989

$ 440	Kemper Open
$ 400	Northern Virginia Charity Golf

		1990
$	4,200	Kemper Open
		1991
$	4,200	Kemper Open
$	2,500	McLean/Tysons Optimist
		1992
$	5,500	McLean/Tysons Optimist

PROTOCOL

		1989
$	150	United Negro College Fund
$	425	Multiple Sclerosis Society
$	800	Project Hope
$	15,000	Meridian House Ball
$	10,000	UNA/USA
$	1,000	Orphan Foundation of America
		1990
$	350	Multiple Sclerosis Society
$	750	Africare
$	25,500	Merdian House International
$	1,500	Friends of Pakistan Gala
$	8,000	U.S. Committee for Unicef
$	15,460	Virginia Gold Cup
$	5,000	Multipel Sclerosis Society
$	6,000	Africare
		1991
$	250	Children's Hospital
$	675	Multiple Sclerosis Society
$	5,000	Friends of Pakistan
$	38,600	Merdian House International
$	3,000	Africare
$	22,662	Virginia Gold Cup
$	3,000	B'nai B'rith Foundation Dinner
$	500	PINATUBO
$	2,000	Medical Education for South African Blacks
		1992
$	7,750	Meridian House International
$	20,000	Virginia Gold Cup
$	600	The Third Africare Bishop John T. Walker Memorial Dinner

INSURANCE DIVISION

1990

$ 1,495	Reach America Drug Awareness Program/DCLUA
$ 400	26th Annual CMGA Member-Guest Tournament 1990 Sponsorship fee for the Crofton Men's Golf Association
$ 918	Advertisement in the 1990 Kemper Open Program/design
$ 2,200	Advertising in the 1990 Kemper Open Program
$ 1,500	United States Committee Sports for Israel/Golf Tournament

1991

$ 500	Crofton Men's Golf Association/sponsorship (AMCAP)
$ 3,100	Ad in Kemper Open Program
$ 1,100	Kemper Open pairing sheet ad
$ 2,000	Boy Scouts of America/1991 Annual Golf Classic
$ 1,000	Washington Bullets: I Have a Dream Foundation two-day event

1992

$ 1,000	Boy Scouts of America/1992 Golf Classic
$ 2,200	Kemper Open Pairing Sheet ad
$ 1,500	U.S. Committee Sports for Israel/golf outing
$ 400	U.S. Olympics/Use of Tournament Players Club of Avenel for the winner of an Olympic Fund Raising Event

BLUE CROSS OF JAMAICA

1989

$ 16,363	Jamaica Teachers' Association
$ 5,454	Medical Symposium
$ 31,418	Health Watch (TV Program)

1990

$ 12,000	Jamaica Teachers' Association
$ 5,600	Medical Symposium
$ 27,648	Health Watch

1991

$ 4,687	Jamaica Teachers' Association
$ 2,604	Medical Symposium
$ 2,864	Nurses Association of Jamaica/International Council of Nurses Conference
$ 17,875	Health Watch

1992

$ 4,090	Jamaica Teachers' Association
$ 2,954	Medical Symposium
$ 20,220	Health Watch

CASCI

		1992
$	25	Corporate Cup

HEALTH MANAGEMENT STRATEGIES INTERNATIONAL

		1991
$	50	National Cancer Institute
$	125	American Cancer Institute
$	35	Roger Mason Maryland Trust Fund

INTERNATIONAL HEALTH BENEFITS

		1991
$	1,000	Howard University (In appreciation for consulting services - donation in lieu of fees)

NATIONAL CAPITAL ADMINISTRATIVE SERVICES

		1991
$	170	Entertaining People/Washington Home
$	50	Donation to the Association of Children's Health
$	400	Donation to Traveler's Aid Society
$	320	1990-1991 Due to Kiwanis Club of Washington, D.C.
$	100	Adopt a family donation

TOTALS FOR 1988-1992 SUBSIDIARY/GHMSI SPONSORED EVENTS

1988	$ 564,256
1989	247,469
1990	144,821
1991	504,436
1992	213,189
GRAND TOTAL	$ 1,674,171

* * *

APPENDIX N

GHMSI BOARD OF TRUSTEES COMPENSATION
1988 - 1991
(Data provided by GHMSI.)

Charlotte G. Chapman	$ 34,200
Charles P. Duvall, M.D.	84,800
Ralph W. Frey	30,400
Thomas R. Harrison	39,000
George W. Jones	30,317
Ira Laster, Jr., Ph.D.	34,900
Peter D. LeNard, M.D.	37,200
Robert C. Mayer	32,600
Victor E. Millar	34,702
Charles T. Nason	3,900*
Lutrelle F. Parker	35,500
Benjamin S. Pecson, M.D.	33,100
Robert E. Petersen	35,600
John E. Sumter, Jr.	29,600
Mallory Walker	20,600**
David S. Wiggin	39,600
Leo W. Zajac	37,200
GRAND TOTAL:	$593,219

* 1991 only
** 1990/91 only.

PREPARED STATEMENT OF MR. WILLIS

Mr. Chairman and members of the Permanent Subcommittee on Investigations, I am Robert M. Willis, Superintendent of Insurance for the District of Columbia.

I want to thank you for the opportunity to appear before you today to further assist your investigation of the Blue Cross/Blue Shield organizations. As you are aware, since my last testimony before this Subcommittee in July 2, 1992, a number of events have transpired raising public and regulatory concerns about the financial condition of the Blue Cross and Blue Shield of the National Capital area. During the course of my testimony, I will refer to this entity, Group Hospitalization and Medical Services, Inc., as "GHMSI."

In my previous testimony I described specific regulatory concerns the District of Columbia had regarding its limited ability to adequately regulate the financial condition of GHMSI. The inability to review transactions between GHMSI and its subsidiaries or affiliates was raised as a major concern, then, and is now the primary focus of the company's financial survival.

I want to personally thank you Mr. Chairman for immediately recognizing the lack of regulatory authority the District of Columbia had over GHMSI. Your July 29, 1992 introduction of S. 3092 to amend Chapter 698 of Public Law 395, as amended, corrected an oversight not foreseen in the 1939 when Congress chartered Group Hospitalization, Inc., the predecessor of GHMSI. As you stated in your floor statement introducing S. 3092:

The 76th Congress, in Group Hospitalization's enabling legislation, exempted the Corporation from the vast majority of the District's insurance regulation. Since then, and especially in the mid-to-late 1980s, the Corporation has grown, surely beyond anything that could have been envisioned in 1939.

Section 7 of the original charter provided:

This Corporation shall not be subject to the provisions of statutes regulating the business of insurance in the District of Columbia, but shall be exempt therefrom unless specifically designated therein.

You also noted in your floor statement, that the superintendent of the District of Columbia could not examine the books and records of GHMSI; require GHMSI to submit to an independent outside auditing firm; or apply the District's insurance solvency standards to the plan.

Mr. Chairman, Public Law 102-382 establishes the District of Columbia as the legal domicile for GHMSI. It requires that the Corporation be licensed in, and regulated by, the laws and regulations of the District of Columbia. It strikes Article 7 of the charter, which exempted the Corporation from regulation by the District of Columbia Insurance Superintendent, and it requires that the Corporation reimburse the District of Columbia for the costs of examination and audit of the Corporation.

Prior to the passage of this new law, GHMSI was not regulated as other insurance companies are regulated in the District of Columbia. All other insurance companies have a State of domicile, which has primary responsibility for the regulation of the company and its financial solvency. Although an insurance company can seek admission to do business in other States, the licensure in foreign jurisdictions subjects the company to the regulatory authorities of the other States. On this basis, GHMSI was admitted to do business in Maryland and Virginia and was subject to the laws and regulations of those jurisdictions.

Mr. Chairman, I welcome the new regulatory responsibility Congress granted when your legislation became law on October 5, 1992. However, later in this testimony, I will comment on the additional steps necessary to complete the District's regulatory authority over GHMSI.

From the time this Subcommittee started its investigations in July 1992, there has been a significant decline in the company's financial condition. At the same time, GHMSI subscribers and providers have had mounting concerns about the financial integrity of the company, in terms of its continuing ability to provide services and to meet its contractual obligations. Apart from subscribers or providers who are more directly affected, there is warranted public concern for the adequacy of the regulation of Blue Cross and Blue Shield entities. In the case of GHMSI, the more visible focus has been on the unbridled diversification strategy (which has resulted in excess of $100 million of losses), gross mismanagement and the absence of effective management and internal controls. However, there is a broader public trust concern that is that GHMSI subscriber rates were used to support a proliferation of businesses which did not lower cost, but in fact, lost money.

These concerns raise two central questions:

1. How did this happen?
2. What should be done to avoid these results in the future?

As to the first question, I think GHMSI management can best that matter. As to the future, it is important to recognize at the outset that GHMSI's problems were both managerial and financial. Therefore, a singular financial remedy does not provide assurance that these results would be avoided in the future.

My testimony will focus on the regulatory steps the District of Columbia has taken to avoid these results in the future, the regulatory changes I think are necessary to adequately regulate Blue Cross and Blue Shield entities and the additional legislative steps necessary to complete the District's regulatory authority over GHMSI. I will also, briefly, provide a general assessment of GHMSI's financial picture and my views on the proposed affiliation between GHMSI and the Virginia Blue Cross and Blue Shield.

REGULATORY STEPS TAKEN BY THE DISTRICT OF COLUMBIA

Fundamental to the exercise of regulatory authority over GHMSI is understanding where company is, where it plans to be in the future and how it will achieve stated objectives. On November 10, 1992, I required GHMSI to provide me a planned of operation demonstrating its plan results over the next 5 years. A few of the specific concerns were:

—a projection of subscriber rates, reserves, and surplus;

—the effectiveness of management and internal control systems;

—a detailed business strategy demonstrating value to the subscriber to keep or sell subsidiary investments; and

—In the event of an affiliation with the Virginia Blue Cross and Blue Shield, I wanted to know the foreseeable impact on subscribers, the provider community and the 4,200 jobs in the District.

I received this report on January 4, 1993, and with the assistance of my counsel and financial consultant, we are in the process of evaluating this report.

My goal is to develop from this data a baseline from which plans and results can be measured and accountability directed. This baseline will also serve as a basis for determining the benefit of an affiliation to GHMSI subscribers.

We have also required GHMSI to become licensed as a domestic insurance company in the District of Columbia and to submit insurance rates and forms for review. The current management has been responsive to these instructions and data requests.

My next major regulatory step was to engage the legal services of the law firm of Mitchell, Williams, Selig, Gates and Woodyard to advise me on the evaluation of a number of regulatory issues, to assist my review of the sale of subsidiary investments and other matters impacting GHMSI's financial condition and to draft appropriate legislation to fully implement the congressional authority to regulator GHMSI.

As you may know, Mitchell, Williams is regarded as a premier law firm in the field of insurance regulatory matters, including the rehabilitation or liquidation of failed companies, where necessary Mr. Ark Monroe, former Commissioner of the State of Arkansas, is the lead counsel assisting me in these matters.

As you can well imagine, the numerical and statistical presentation of GHMSI's 1992 results, 1993 plans and the required plan of operation is a huge task. Therefore, I have engaged the public accounting firm of Ernst & Young to assist my evaluation of the following areas:

—the reasonableness of financial projections and business assumptions contained in the plan of operation;

—GHMSI's current and projected financial condition and the management parameters necessary to monitor these results;

—the adequacy of management and internal control systems; and,

—the financial exposure of future losses and contingent liabilities resulting from the sale or termination of subsidiary investments or other third party contracts.

Although I have not received an affiliation proposal, Ernst & Young will provide an indepth financial analysis of the transaction and quantify the foreseeable impacts on the Washington metropolitan area market place.

REGULATORY CHANGES NECESSARY TO ADEQUATELY REGULATE BLUE CROSS AND BLUE SHIELD ENTITIES.

1. Blue Cross/Blue Shield entities should be required to provide standardized management reports to assist the regulatory review of a company's financial condition. Although reports demonstrating subscriber service standards and other indicia of financial condition are routinely provided to the National Blue Cross and Blue Shield Association, this data is not required to be provided to State regulators.

My understanding is that the Blue Cross and Blue Shield Association has in place systems to monitor an affiliate operating results. In fact, this data base was used to point out impending financial problems to prior GHMSI management, but was apparently disregarded. The subsequent results begs the question whether the association acted appropriately in not insisting that its service and financially based operating standards be strictly adhered to at that time.

2. It should be mandatory that Blue Cross/Blue Shield entities obtain prior approval from the domestic insurance regulator before any investment of subscriber surplus in either in health service plans or non-health service subsidiaries or affiliates, or any third party transactions, which would materially impact the financial condition of the company. This requirement would place the burden on the Blue Cross/Blue Shield entities to demonstrate the benefit of the investment to the subscriber. I also think that it would be appropriate to determine if the franchise license agreements between the Blue Cross and Blue Shield Association and Blue Cross/Blue Shield entities ("BCBS") should be restructured to obtain association approval prior to requesting regulatory approval of such transactions.

3. Where Blue Cross/Blue Shield entities, such as GHMSI, are engaged in interstate subscriber contract business (based on the geographical areas designated in the Blue Cross and Blue Shield Association franchise license agreement), primacy must be given to the solvency standard established by the domestic regulator to avoid the financial management of a company being dictated by foreign jurisdictions. In those instances where a foreign jurisdiction requires solvency standards greater than the domestic State, the insurance rates charged in the foreign jurisdiction should reflect the additional reserve requirement.

In the case of GHMSI, there are three separate solvency standards being applied. The District of Columbia requires life and health companies to maintain $1.5 million in surplus. My understanding is that Maryland requires a minimum of $75,000 of surplus or a maximum reserve equal to 2 months of claims and operating expenses. In Virginia a minimum contingency reserve is required which shall not exceed 45 days of anticipated operating expenses and incurred claims expense, etc., and it applies to nonstock corporations. Thus, you can see the wide variance in solvency requirements. It is important to recognize that while the District standard is based on surplus the Virginia and Maryland standards are based on a reserve calculation. As such, the rates of insurance should reflect these charges.

This recommended solvency standard approach would ensure that adequate financial reserves are being maintained to meet the particular requirements of State laws uniquely structured to protect subscribers in foreign jurisdictions. Any other approach could result in an interstate Blue Cross/Blue Shield entity being managed to meet extra-territorial requirements which may not benefit all subscribers.

Resolution of this solvency issue is important to the probable future consolidations or merger of other Blue Cross/Blue Shield plans to achieve necessary operating efficiencies.

4. Consideration should be given to the establishment of civil and criminal penalties against officers and directors who by their actions or inactions abuse the public trust. Blue Cross/Blue Shield officers and directors should be held to fiduciary standards to protect subscriber and provider interest in service standards and in maintaining a financially solvent operation. Officers and directors should not be allowed to squander subscriber surplus or embark on business strategies resulting in over $30 million being lost on subsidiary investments, such as World Access Inc.

As you know, the National Association of Insurance Commissioners ("NAIC") established a special committee of Blue Cross plans in 1992. This committee issued a report in December 1992 which, I understand, Commissioner Foster will comment on as a part of his testimony.

LEGISLATIVE STEPS NECESSARY TO IMPLEMENT FULL REGULATORY AUTHORITY OVER GHMSI

In order to fully implement the Congressional authority to regulate GHMSI, my outside counsel is drafting a comprehensive District of Columbia statute regulating group nonprofit health service plans (and supporting regulations) which provide the levels of subscriber protections I have outlined in my testimony. We will share the proposed regulatory structure with the Maryland and Virginia commissioner for advise and comments.

By March 1, 1993, I expect to have this emergency legislation ready for submission to the District of Columbia Council for review and enactment. Within the District of Columbia legislative system, this emergency law would be immediately effective, for 90 days, allowing an opportunity for temporary and permanent legislation to be enacted.

During this interim period, in which the District does not have a comprehensive legislative package in place, I will ask GHMSI to sign a consent order to serve as a short term measure to achieve this full regulatory authority.

When permanent legislation is enacted by the Council, we will need the support of this Subcommittee in seeking the swift passage of this legislation. At that point in time, I think it would also be appropriate that Congress repeal GHMSI's Federal charter. With comprehensive legislation in place in the District, GHMSI should be treated as other Blue Cross/Blue Shield entities under the laws of their State of domicile and State of licensure.

GHMSI'S FINANCIAL CONDITION.

As I noted earlier in my testimony, the accounting firm of Ernst & Young has been engaged to provide me an indepth assessment of GHMSI's current and projected financial condition. However, I do think it is important to comment on the source of the current financial problem. A clear distinction has to be drawn between GHMSI's core subscriber contract business and other subsidiary operations.

Based on GHMSI's 1992 financial summaries, the core health business earned $8.1 million, whereas the other subsidiary businesses accounted for $26.8 million in losses. At this point in time, the problem is getting a clear picture as to the magnitude of these losses in the future because a number of contingent liabilities continue, even though subsidiary businesses may be sold or terminated. A recent newspaper article reporting a $39 million loss in 1992, fails to illustrate the point that the core health business relied on by subscribers and providers was profitable in 1992. GHMSI's 1993 business plan shows the same basic pattern of a profitable core business and substantial losses on subsidiary investments.

The key risk not shown in these figures is whether GHMSI can maintain this profit profile on the core business, given deteriorating results in its affiliated businesses and mounting negative publicity.

PROPOSED AFFILIATION STRATEGY

As a practical matter, the proposed affiliation between GHMSI and the Virginia Blue Cross and Blue Shield appears to be a very logical approach to reduce long term costs and benefit subscriber rates. In my opinion, current GHMSI management has taken the right step in evaluating this financial alternative. Since there has been no presentation of a proposed affiliation strategy to consider, it is speculative to try and anticipate what the District's regulatory response would be.

Regardless of the form of the transaction, my primary concern is its impact on subscriber rates, reserves and surplus, the provider community and local jobs. On a broader plane, I would expect that the financial transaction would be structured to ensure competitiveness throughout the Washington metropolitan area to the benefit of all GHMSI subscribers.

In my opinion, the Blue Cross and Blue Shield Association must be a key player in any affiliation strategy. I have met with representatives of the association and expressed my view that it must be a part of what ever strategy is necessary to restore GHMSI to financial health, even if this means measures other than an affiliation with the Virginia Blue Cross and Blue Shield. During the period GHMSI ventured into the realm of diversification, the association was aware of the financial risks and deteriorating results. It seems to me the association had a responsibility to bring these matters not only to the attention of key officers, but also to the attention of the GHMSI board of directors.

In conclusion, I will say that, as a domestic regulator, my primary focus is the financial survival of GHMSI to protect the interests of subscribers and providers. If an affiliation with the Virginia Blue Cross and Blue Shield is shown to be the best vehicle for addressing management and financial deficiencies and does not disrupt the competitive environment, I will more than likely support such a strategy. Since GHMSI is domiciled in the District, we should be the quarterback of the financial rescue effort with firm and steadfast assistance from the regulators in the other jurisdictions in which GHMSI is admitted—Virginia and Maryland. One regulator cannot try to solve this alone or the whole concept of State regulation is meaningless. States must work together to find common ground for the benefits of all subscribers. I believe the Congress recognized the primacy of the District's responsibility when it passed the legislation last fall. I intend to carry out these responsibilities to the best of my ability. Again, accomplishing the best result for all GHMSI subscribers will require active cooperation between all regulatory officials and GHMSI management.

Since the management change made as of October 1, 1992, I have found the level of cooperation and candor of GHMSI management to be prudent and responsible. While we may still disagree on some points, the objective to benefit subscribers remains steadfast.

Thank you for allowing me this opportunity.

PREPARED STATEMENT OF MR. FOSTER

Good morning Mr. Chairman, Members of the Permanent Subcommittee on Investigations, ladies and gentlemen. I am Steven T. Foster, Commissioner of Insurance for the Commonwealth of Virginia, and the President of the National Association of Insurance Commissioners (NAIC). The NAIC is the association of the chief insurance regulatory officials of the 50 states, the District of Columbia, Puerto Rico, American Samoa, Guam, and the Virgin Islands.

As President of the NAIC I have submitted separate testimony. In my capacity as the chief insurance regulator in Virginia, I will discuss regulatory steps taken by the Virginia State Corporation Commission Bureau of Insurance in connection with Group Hospitalization and Medical Services, Inc. (GHMSI), the Blue Cross and Blue Shield Plan serving the Washington, D.C. area, which has been the subject of this subcommittee's investigation.

As Commissioner of Insurance for the Commonwealth of Virginia, I am appointed by the State Corporation Commission to administer the insurance laws of Virginia and to make recommendations to the State Corporation Commission for regulatory action against insurers and prepaid health services plans, when warranted, in accordance with Virginia law. A central focus of Virginia's insurance laws is the solvency, that is the ability to pay obligations, of insurers and prepaid health services plans licensed and doing business in Virginia.

GHMSI is a foreign non-stock corporation organized under the laws of the United States by federal charter and licensed in Virginia as a health services plan under Chapter 42 of Title 38.2 of the Code of Virginia. Critical developments with GHMSI's financial condition and method of operation have greatly heightened my concern about GHMSI's ability to meet Virginia's solvency standards and to continue to operate within the Commonwealth's borders.

Virginia's laws regarding solvency are not limited to oversight of domestic corporations. Traditionally, however, the state system of regulation looks to the domiciliary jurisdiction to take the lead in regulating the insurers and prepaid health plans organized under its laws. Where the home jurisdiction is unwilling or unable to regulate, other states must actively ensure protection for their policyholders.

GHMSI's federal charter has provided a unique situation and challenge to state regulation. As Superintendent Willis has testified before this subcommittee on July 2, 1992, the District of Columbia has traditionally viewed its ability to regulate GHMSI as severely constrained by Congressional act. Yet GHMSI's past management has taken ample opportunity to point to those sections of Virginia law which give seeming deference to a carrier's home jurisdiction. At the same time, GHMSI continued to enjoy the purported shield of its federal charter in the jurisdiction where it does the majority of its business, the District of Columbia.

As I stated, however, Virginia has refused to abdicate its solvency monitoring responsibilities toward this non-domestic health services plan operating in its northern cities and counties. In the past, Virginia has worked with Maryland to conduct on-site financial examinations. When GHMSI's 1991 Annual Statement indicated major reporting problems and troubling financial developments, especially in its relationships with subsidiaries, Virginia not only required filing of an amended Annual Statement, but dispatched its examiners in April of last year to conduct an on-site target review of critical areas. This target review confirmed major areas of solvency concerns and noncompliance with Virginia law. This target review, first of all, resulted in the State Corporation Commission's Consent Order of August 3, 1992, which, among other things, provided for Commission approval of all affiliate transactions. Secondly, I directed my examination staff to conduct and supervise a full statutory financial condition examination. It is this examination which has uncovered the full extent of GHMSI's precarious financial condition today.

GHMSI's status as a federally chartered organization with its broad charter exemptions has frankly hindered our regulatory efforts. Especially troubling has been GHMSI's history of using the ambiguities of its federally chartered status to attempt to blunt the tools of Virginia's solvency regulation. A good example is GHMSI's compliance with Virginia's holding company act. Prior to July 1, 1989, health services plans were generally subject to Virginia's insurance holding compa-

ny act embodied in Article 5, Chapter 13 of Title 38.2. However, GHMSI took the position that it was exempt from the act by virtue of Section 38.2-1329 of Article 5, which specifically excluded foreign insurers and health services plans from the registration act under the following circumstance:

This section shall not apply to:

> Any foreign insurer subject to disclosure requirements and standards adopted by statute or regulation in the jurisdiction of its domicile that are substantially similar to those contained in this section.

In early 1989, the State Corporation Commission Bureau of Insurance came to doubt GHMSI's position that its so-called holding company filings with the office of the Superintendent of the District of Columbia constituted grounds for an exemption. In February, 1989, the Bureau of Insurance sent a letter to GHMSI's corporate secretary and general counsel that GHMSI was deemed subject to holding company filings in Virginia. During this time, the State Corporation Commission also supported new holding company legislation in the 1989 Virginia General Assembly specifically applicable to health services plans. This new legislation contained lower threshold requirements for regulatory approvals and imposed more rigorous standards for approval of affiliate transactions. Passed by the General Assembly, this law became effective July 1, 1989.

GHMSI's responded to the Bureau letter on February 28, 1989. Essentially, GHMSI stated it was not subject to Virginia's holding company requirements since the District of Columbia had a similar statute. After several discussions with GHMSI's legal staff and the staff of the District of Columbia, Virginia reiterated its position and directed GHMSI to file. On April 12, 1989, I wrote to the then Superintendent of the District of Columbia Insurance Department asking whether GHMSI was subject to the holding company act in the District of Columbia. On April 17, 1989, the Superintendent sent me a letter stating that my letter of April 12th had been forwarded to GHMSI for a response. In lieu of a direct response from the Superintendent, I received from GHMSI's general counsel a letter on May 2, 1989, with an attached legal opinion stating that GHMSI would be subject to some of the major provisions of the new holding company legislation effective on July 1, 1989, but that it would be exempt from the registration requirements. In addition, the opinion claimed that GHMSI was not subject to the registration requirements of the existing Virginia holding company laws.

On May 4, 1989, the State Corporation Commission issued a formal Show Cause Order requiring GHMSI to show cause why the Commission should not suspend or revoke GHMSI's license for its failure to comply with Virginia law. However, a hearing was not necessary as GHMSI began to make filings under Virginia's holding company laws, culminating in the filing of the full requisite registration statement on July 14, 1989.

This short history does not fully convey, however, the perennial resistance of GHMSI to make full and adequate disclosure in its holding company filings. Considerable time on the part of my staff was spent corresponding in writing and by telephone especially with GHMSI's former chief financial officer and general counsel on providing the documentation necessary to understand fully the nature and impact of affiliate transactions and relationships. Responses were vague and incomplete. Often written contracts did not exist to support filings. For example, GHMSI's surplus contribution to Blue Cross and Blue Shield of Jamaica lacked full and appropriate documentation. Initially, the chief financial officer represented that GHMSI made a five million dollar cash infusion simply as an equity investment. Subsequently, the chief financial officer spoke of the investment as a debt instrument. Only after my staff pressed for documented evidence of ownership or debt did it become clear that GHMSI had simply wire-transferred five million dollars to Jamaica. Virginia had to disallow this investment as an admitted asset. This so-called investment presently totals six and a half million dollars.

In GHMSI's 1991 Annual Statement, large reinsurance transactions and improper reporting raised not only financial concerns but pointed again to serious non-compliance with Virginia's holding company act. Although Virginia's examination statutes prohibit my discussing the specific results of that examination report until it becomes a public document, I will say that during this past year the Bureau's general analysis of GHMSI's recent affiliate transactions indicates that management never intended to comply fully with Virginia's holding company requirements. Hence, the State Corporation Commission issued its Consent Order on August 3, 1992, requiring approval of all affiliate transactions regardless of any thresholds.

Though compliance with Virginia's holding company laws is a good example of attempts by GHMSI's past management to use its federal charter to its own advan-

tage, it is not the only example. In 1990, Virginia amended its investment statutes to subject foreign carriers, including health services plans, to Virginia's investment regulation if their domiciliary jurisdictions did not regulate investments. The act was clearly aimed at GHMSI. When questions of GHMSI's compliance arose early this year, GHMSI asserted it was subject to the investment laws of the District of Columbia and therefore not to Virginia's statutes. Yet our understanding is that the District of Columbia could not bring to bear its investment laws until its jurisdiction on this matter was clarified by Congressional act on September 30, 1992.

Despite this federally chartered organization's resistance to Virginia's oversight, Virginia's financial monitoring has brought attention to what is now a critical juncture in GHMSI's history and prospect for survival. Under Virginia law, I feel I have the regulatory tools to fulfill my obligations to protect Virginia subscribers. GHMSI must and will be required to meet basic standards of financial solvency. It will not be allowed to operate in Virginia as a "quasi public social agency" with an inadequate capital base. It must be able to compete with its products and prices in the market place as an economically viable entity. If it is unable to meet Virginia's financial standards, I will do what I can to help with its orderly exit from Virginia's market place. Ultimately, of course, Virginia subscribers have the protection of the Virginia Life, Accident and Sickness Insurance Guaranty Association.

I am not so naive, of course, to think that GHMSI's disappearance from the Virginia market place would not cause disruptions in people's lives and in the market place. My staff and I have spent considerable effort, therefore, in working with GHMSI's present management in exploring solutions acceptable to Virginia and to the regulatory authorities in Maryland and the District of Columbia. We have been clear and forthright in communicating Virginia standards and the consequences of not meeting them. Ultimately, GHMSI must find the means to comply.

On November 17, 1992, my staff and I held a meeting with representatives of GHMSI and its outside auditors, Price Waterhouse. The purpose of the meeting was to discuss the high probability of GHMSI's inability to meet Virginia's basic reserve requirement equal to forty-five days of claims and operating expenses. The prospect of shutting down in Virginia was placed squarely on the table. Recognizing the monopoly of the National Blue Cross and Blue Shield Association over the Blue Cross and Blue Shield trademarks, I concurred with the National Association's attendance.

At the meeting, the National Association offered no solutions except to ask Virginia to explore ways to lessen its reserve requirements until a solution could be found. We asked for concrete answers to our concerns.

As a result of that meeting, GHMSI together with the National Blue Cross and Blue Shield Association offered for Virginia's consideration the alternatives of a fifteen million dollar capital infusion in the form of a surplus note, and reinsurance of all new business in Virginia to give GHMSI breathing room for a longer term solution. The capital infusion was to come from the National Blue Cross and Blue Shield Association, and the reinsurance would be provided by an Illinois carrier licensed in Virginia, BCS Life Insurance Company. I accepted both alternatives as a legal means to take care of GHMSI's immediate problems. The surplus note appeared to allow GHMSI to meet Virginia's reserve requirement and the reinsurance treaty helped alleviate some other immediate concerns about GHMSI's overall financial condition. Both mechanisms were put in place at the beginning of December.

I have also, where appropriate, facilitated communications between GHMSI and Blue Cross and Blue Shield of Virginia as they have explored some type of affiliation. I want to stress, however, that have not exerted any pressure on Blue Cross and Blue Shield of Virginia either to affiliate or disassociate itself from GHMSI. In line with my duties as the domiciliary regulator of Blue Cross and Blue Shield of Virginia, I expressed caution about putting the funds of Virginia subscribers at risk and the ability of all Virginians to purchase Blue Cross and Blue Shield coverage.

I thank the Subcommittee for the opportunity to testify today.

PREPARED STATEMENT OF THE NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

INTRODUCTION

Good morning Mr. Chairman, Members of the Permanent Subcommittee on Investigations, ladies and gentlemen. I am Steven T. Foster, Commissioner of Insurance for the Commonwealth of Virginia, and the President of the National Association of Insurance Commissioners (NAIC). The NAIC is the association of the chief insur-

ance regulatory officials of the 50 states, the District of Columbia, Puerto Rico, American Samoa, Guam, and the Virgin Islands.

The NAIC and the state insurance departments continue to work with the federal government to enhance our ability to provide American insurance consumers and taxpayers with sound regulatory protection. We applaud this Subcommittee for its excellent work in the investigation of the regulation of insurance, and pledge our continued cooperation and support in this worthy effort.

On behalf of state insurance regulators, I welcome this opportunity to present to the Members of the Subcommittee a report on the regulation of Blue Cross/Blue Shield plans across the nation—what we have accomplished so far, and what we will be doing in the coming months.

I also appear today in my capacity as the chief insurance regulator in Virginia. In that capacity, I have submitted separate testimony concerning the specific regulatory steps taken by the Virginia State Corporation Commission's Bureau of Insurance in connection with the Group Hospitalization and Medical Services, Inc. (GHMSI), the Blue Cross/Blue Shield Plan serving the Washington, D.C. area which has been the subject of this committee's examination.

THE WORK OF THE NAIC

State regulators share the concern of this Subcommittee that the millions of participants in the 73 Blue Cross/Blue Shield plans across the nation be well-protected from the risk that their plans might become insolvent. To that end, for the last year, the NAIC's Special Committee on Blue Cross Plans has reviewed the oversight of these plans, including such issues as reserve requirements, rate adequacy, risk-based capital requirements, investment and reinsurance limitations, inter-company transactions, and others. That committee submitted its report to the NAIC's Executive Committee in December 1992 (Attachment A).

In reviewing the findings and recommendations of the NAIC Special Committee, it is important to keep in mind the unique place in our history occupied by Blue Cross/Blue Shield plans. Formed in the 1930s and 1940s as prepaid hospital and medical service plans, the "Blues" are generally organized and regulated under special statutes in each state designed specifically for such plans. In many states, Blues plans are not regulated under the same laws and regulations as are commercial insurers, although some of the states are reconsidering this approach. For example, nine plans have organized as life and health insurers, and five have organized as property and casualty insurers.

The variation in regulatory approaches taken by the various states can be attributed to the fact that Blues plans generally operate in only one state, and can serve social functions that differ significantly from one state to the next. In some states, for example, the Blues are considered the "insurer of last resort," required to take all applicants, while in other states, the Blues are just another provider of health insurance.

This diversity is reflected not only in the structure, purpose, and regulatory environments of Blue Cross/Blue Shield plans, but in the financial condition of such plans. Some plans are facing financial troubles, while others are in excellent condition.

With all that said, let me now highlight a few of the key findings of the Special Committee.

MINIMUM FINANCIAL STANDARDS AND RISK-BASED CAPITAL

The Committee expressed its concern that in some cases, minimum financial standards for Blues plans are inadequate or nonexistent. In some cases, state insurance departments do not have clear authority to regulate plan investments, reinsurance and management practices. To address this concern, the Committee recommended the consideration of minimum financial standards for Blues plans, including the question of whether risk-based capital standards should be developed for the plans.

FINANCIAL REPORTING REQUIREMENTS

The Committee also examined reporting requirements for Blues plans, and found that many of the reporting and accounting standards that have been developed by state regulators in recent years for multi-state insurers have not been applied to the plans. As a result, it is not currently possible to develop a national financial database for Blues plans, nor is it possible to compare with any degree of consistency one plan to another or a Blues plan to a commercial insurer.. The Committee there-

fore has recommended that the NAIC develop a more uniform system of financial reporting for Blues plans.

GUARANTY FUND PROTECTION

The Special Committee found that only 22 of the 73 plans participate in guaranty funds. While this is a cause for concern among regulators, the Committee was careful to note that there are several difficult issues that need to be considered before the conclusion can be reached that the plans should be included with commercial insurers in guaranty associations. Accordingly, the Special Committee recommended that the NAIC look more closely at the question of whether it is appropriate to require Blues plans to participate in state guaranty associations.

REGULATION OF SUBSIDIARIES

One of the issues of particular interest to this Subcommittee has been the regulation of transactions between Blues plans and their subsidiaries. The Special Committee, too, studied this issue, and found both inconsistency in the various regulatory approaches taken by the states on this issue and, in some cases, inadequate regulation. The Committee has recommended to the NAIC that it look more closely at this issue, with an eye toward the development of regulatory standards to assure that states have the authority to regulate affiliate transactions of Blues plans, perhaps through the development of a new model law.

The report of the Special Committee was received by the NAIC Executive Committee last month, and is currently under review by that Committee. I expect that the Executive Committee will take up the Special Committee's recommendations at its meeting in March of this year. James E. Long, the North Carolina Commissioner and Past President of the NAIC, who has testified before this Subcommittee on several occasions, will chair the NAIC's Special Committee on Blue Cross Plans in 1993. Some of the issues we anticipate the Special Committee will, under Commissioner Lang's leadership, address in 1993 include:

—the overall regulation of Blues plans, including the public policy, legal, and business environment in which particular Blues plans operate and the differences in methods of operation;
—the development of minimum capital requirements for Blues plans;
—the development of a more uniform system of financial reporting for Blues plans;
—whether and how Blues plans should be integrated into the state guaranty fund systems and whether state receivership laws are applicable to Blues plans; and
—whether current state laws related to corporate governance, accountability, and Blues plan acquisition of and transactions with affiliates are adequate to assure appropriate regulatory authority over such acquisitions and transactions.

CONCLUSION

As you have heard, state insurance regulators and the NAIC are taking the regulation of Blue Cross/Blue Shield plans very seriously. We are taking a hard, clear-eyed look at the regulation of this important component of the health care delivery system, with a full appreciation of the seriousness of the task of protecting the over 80 million Americans who rely on these plans for their health insurance.

We are acutely aware of the limitations of the current regulatory system for the plans, and are firmly committed to elevating the regulatory standards for Blue Cross/Blue Shield plans. Naturally, we will keep this Subcommittee fully informed of our efforts.

Thank you.

ATTACHMENT A

REPORT OF THE SPECIAL COMMITTEE ON BLUE CROSS PLANS

In response both to the insolvency of Blue Cross and Blue Shield Plan of West Virginia and to the growing regulatory concern over the adequacy of the law. and regulation. governing Blue Cross and Blue Shield ("BC/BS") plans across the country, the NAIC in 1991 appointed the Special Committee on Blue Cross Plans to study issues relating to BC/BS plans.

The charge of the Special Committee on Blue Cross Plans is:

Identify solvency issues related to Blue Cross/Blue Shield organizations, and review current regulatory oversight of these issues. Issues to be reviewed include rate adequacy, reserve requirements, risk based capital requirements, investment and reinsurance limitations, inter-company transactions and the adequacy of current regulations for dealing with Blues insolvencies, including guaranty fund participation and/or Blue Cross/Blue Shield Association guaranty mechanism.

To carry out this charge, the Special Committee undertook a thorough review of the current regulatory structure for BC/BS plans. As part of this effort, the Special Committee conducted a survey of state insurance departments to identify their regulatory concerns and suggestions for change. The Special Committee also received information from the Blue Cross and Blue Shield Association ("Association") and conducted a survey of the individual BC/BS plans across the nation.

As a result of its work, the Special Committee has gained a unique perspective because it has acquired a working knowledge of the factual, legal and policy underpinnings of the issues which the Special Committee has identified for further action by the NAIC.

Given this unique perspective, the Special Committee believes that it should serve as the vehicle for coordinating and executing activities related to these identified activities. The Committee recommends these tasks be centrally coordinated because delegation of these issues to an array of NAIC committees would have a deleterious impact on the ability of the NAIC to reach resolution of these issues. To illustrate the Special Committee's point, many of the specific inquiries that will be made deal with insurance and business structures that are in many ways unique within the business of insurance.

The report begins with a brief description of the BC/BS system. It is followed by a discussion of the principal issues and concerns identified by state regulators in the survey conducted by the Special Committee and the Special Committee's recommendations for further action.

Briefly, the Special Committee recommends that the NAIC charge the Special Committee exclusively or in appropriate combination with other NAIC committees to:

—Evaluate the overall regulation of BC/BS plans: such an evaluation should focus on public policy, legal, and business environment in which particular BC/BS plan. operate (e.g., insurer of last resort, community rating, extent of community rate regulation) and consideration should be given to the differences in methods of operation, including the impact of subsidies relating to BC/BS plans, when formulating standards for regulatory oversight and financial condition.
—Evaluate the role played by the Association in the regulation and operation of member plans, including Association financial standards, the adequacy of internal discipline, inter-plan bank transactions, and enforcement of Association standards, and consider provisions for the examination of the Association on a regular basis.
—Recommend minimum capital requirements for BC/BS plans; study and test alternative methodologies, including but not limited to risk based capitol approaches; determine the feasibility and application of risk-based capital standards to BC/BS plans of various types or categories.
—Develop a more uniform system of financial reporting for BC/BS plans.
—Evaluate whether and how BC/BS plans should be integrated into the state guaranty fund systems and assess the applicability of state receivership laws to BC/BS plans.
—Evaluate current state laws related to corporate governance, accountability, and BC/BS plan acquisition of and transactions with affiliates and develop regulatory standards to assure appropriate regulatory authority over such acquisitions and transactions.

THE BC/BS SYSTEM

The BC/BS system developed in late 1930 and early 1940 as a system of prepaid hospital and physician benefits offered to individuals and to employer groups. BC/BS plans operate in limited service areas, usually statewide, although several states have more than one BC/BS plan and in a few instance. BC/BS plans operate across state lines.

There are 73 BC/BS plans throughout the United States and Puerto Rico. The majority of these plans are organized and regulated under special statutes (in some

cases dating back to 1930) designed specifically for BC/BS-type [1] plans. Nine plans are organized as mutual life and health insurers, and five plans are organized as mutual property and casualty insurers.

The organization and regulation of BC/BS plans vary significantly from state to state. In many states, BC/BS plans are not subject to the general laws and regulations governing commercial insurers.[2] The special statutes governing BC/BS plans in these states differ considerably, especially in the areas of financial standards and the level of regulatory authority provided to regulators. In some cases these statutes were enacted decades ago, and often they have not been updated to reflect changes in insurance and financial practices, particularly in the area of corporate structure.

To use the names "Blue Cross" and "Blue Shield," each of the plans has entered into an agreement with the Association. The Association is a non-profit corporation incorporated in the State of Illinois, whose primary purposes are: (1) to protect the BC/BS service marks; (2) to act as a clearinghouse in support of its member plans; (3) to coordinate the national programs of its member plan; and (4) to coordinate government programs. The Association essentially acts as a trade association for the plans; each plan is independently operated and the Association provides no financial guarantees with respect to the plans.

REGULATORY ISSUES AND RECOMMENDATIONS

In the course of its review of the BC/BS system, the Special Committee has identified several important issues for further consideration by the NAIC.

Role of the Association

The Special Committee investigated the internal financial standards and disciplines the Association applies to its member plans. The committee found there is ample warrant to determine the adequacy of the financial standards applied by the Association to member plans as well as the adequacy and effectiveness of the internal disciplines.

The Special Committee recommends that the NAIC include in its 1993 charges: (a) whether the Association has adequate internal financial standards for its member plans; (b) whether the Association adequately enforces its internal standards; and (c) whether changes should be made to the Association's internal discipline of it member plans.

Surplus and Reserve Standards

The absence of well-developed financial standards for BC/BS plans, including minimum reserve and surplus requirements, is a concern frequently raised by insurance regulators about BC/BS plans. As mentioned above, many BC/BS plans still operate under out-dated statutes, and many of the financial and reporting standards and requirements that have been developed by regulators in recent years for commercial insurers have not been applied to BC/BS plans. For example, eleven states have no minimum surplus requirements for BC/BS plans, and many states do not have clear authority to regulate plan investments, reinsurance and management practices, and market of last resort concerns that may have an impact on surplus adequacy.

In addition, BC/BS plans have not been included in the NAIC's recent efforts to develop risk-based capital guidelines for insurers. Over the past two years, the NAIC Life and Health and the Property and Casualty Risk-Based Capital Working Groups have been evaluating formulas to apply risk-based capital tests to life and health insurers and property and casualty insurers. The goal of these efforts is to develop guidelines for minimum capital that reflect the types of insurance and investment risks affecting each insurer. Thus far, these Working Groups have not considered the applicability of the tests being developed to BC/BS plans.[3]

The Special Committee recommends that the NAIC include in its 1993 charges the consideration of minimum financial standards for BC/BS plans. The Special

---

[1] These plans are often designated as prepaid hospital and prepaid medical service plans in these statutes.

[2] Unlike the laws regulating commercial insurance, there has been little effort by the states to establish consistency and uniformity of regulation across states. In part, this lack of consistency and coordination can be explained by the fact that each BC/BS plan largely operates only in one state. Further, the special status and responsibilities that BC/BS plans have assumed in a number of states (i.e., as insurer of last resort) has contributed to the development of different statutory and regulatory systems.

[3] The Association has begun developing risk-based capital standards for BC/BS plans. The Special Committee has requested, but not yet received, the Association's risk-based capital formula or the preliminary results of the testing of these formulas on the BC/BS plans.

Committee further recommends that the appropriate application of risk-based capital standards to BC/BS plans be evaluated.

Financial Reporting and Accounting

A related concern raised by many regulators is the lack of standardization in the financial reporting and accounting of BC/BS plans. Because each plan operates only in a single state, many of the financial reporting and accounting standards applicable to multi-state insurers have not been applied to BC/BS plans.

These differences in financial reporting requirements make it difficult to compare and analyze BC/BS plans on a national basis. For example, the Special Committee's research found, 14 BC/BS plans file the Blue or Yellow blank, 57 plans file the White (HMDI) blank, and 2 plans file the HMO blank. Unlike most commercial insurers, most BC/BS plans are not required to submit financial information to the NAIC and are not subject to other reporting requirements such as those for audited financial statements, actuarial opinions on reserve adequacy, and management discussion and analysis reports.

In addition, the Special Committee has identified several questions related to reporting and accounting of financial transfers between plans. The Association operates an inter-plan service benefit bank and reciprocity program to process the reimbursement of medical expenses incurred by BC/BS member plans when enrollees receive services in another state. According to the 1991 financial report of the Association, $874 million was processed through this inter-plan bank during 1991. The Special Committee has questions regarding whether controls over inter-plan bank accounting are sufficient to prevent plans from using the bank for purposes of disguising future claim obligations, and thus overstating plan surplus.

The Special Committee recommends that the NAIC include in its 1993 charges the development of a more uniform system of financial reporting requirements related to all inter-plan transfers and correspondingly with the Association.

Participation in State Guaranty Funds

BC/BS plans are members of state guaranty funds in only 22 states at the present time. The committee is concerned that the lack of guaranty fund protection leaves BC/BS subscribers at greater financial risk than the policyholders of commercial health insurers.

The Special Committee believes consumers are generally unaware that BC/BS is not a nationwide insurer, and often believe that they have the protection of a large, national concern that will provide reimbursement of their health care needs. Actually, the financial protection of BC/BS subscribers depends on the financial strength of their particular BC/BS plan. The insolvency of Blue Cross and Blue Shield of West Virginia demonstrates the problems that affect both consumers and providers when no guaranty fund protection is provided.

At the same time, the Special Committee has identified several issues that must be considered before BC/BS plans in at least some states can be included in state guaranty funds. For example, in some states BC/BS plans have very high market share, and including these plans in the guaranty fund would significantly affect the financial responsibilities of both the BC/BS plans and the other guaranty fund participants. Questions also have been raised about the appropriateness of including BC/BS plans and commercial insurers, which in some states are subject to different regulatory standards and requirements, in the same guaranty fund. Potential federal government responsibility for obligations, etc., for insolvencies should be considered where the plan administers Medicare or Medicaid.

The Special Committee recommends that the NAIC include in its 1993 charges the evaluation of whether and how BC/BS plans should be integrated into the guaranty fund system.

Regulation of Subsidiaries

As discussed above, the statutes governing BC/BS plan operations vary considerably from state to state. Some states have expressed the concern that they do not have sufficient regulatory authority over the financial dealings between BC/BS plans and their affiliates. The Special Committee's survey indicates that BC/BS plans are not subject to holding company acts in many states. In the opinion of some state regulators, this lack of authority over affiliate transactions seriously undermines their ability to oversee the financial status of the BC/BS plans in their states.

It should be noted that in 1946 the NAIC developed a Model Act to Provide for the Incorporation of Nonprofit Hospital Service Plan Corporations. This model act was based on the original authorizing legislation for the early BC/BS plans. The model act is outdated, but could serve as a vehicle for development of a new model

act for BC/BS plans to address some of the issues that have been identified, such as affiliate transactions and minimum financial requirements.

The Special Committee recommends that the NAIC include in its 1993 charges an evaluation of the current state laws related to BC/BS plans, especially in the area of affiliate transactions and acquisitions. The Special Committee further recommends that regulatory standards be developed to assure appropriate regulatory authority over the affiliate transactions of BC/BS plans. The NAIC should also consider addressing the issued that have been identified through the development of a new model law for BC/BS plans.

CONCLUSION

The Special Committee believes that the issues identified above are of extreme importance and need to be addressed by the NAIC in 1993. Over 80,000,000 individuals are covered through the BC/BS system, and the financial strength and accountability of that system are an important regulatory and public policy concern.

PREPARED STATEMENT OF DR. DUVALL

Senator Nunn, and members of the Subcommittee:

It is important that we meet together here today to discuss the affairs of the Blue Cross and Blue Shield Plan of the National Capital Area since the directors and management of the Plan share with this Committee and its Staff an abiding and overriding common interest in the best interest of our subscribers, the citizens of the Greater Metropolitan Washington Area. This is a public entity, a not-for-profit corporation, and it does, indeed, stand accountable. When problems develop the most important job is to analyze their cause and to provide constructive solutions.

I am before you today representing not only myself, but the 40 plus men and women who have served proudly and with great distinction on this Board over the past several years. At the time when the Blue Cross and Blue Shield Organizations merged, the combined Board was 36 strong, 15 were providers, physicians and hospital administrators. The rest, 21, were citizens of the local community. Changes over the years have now reduced the size of the board to 12 members with one physician and one hospital administrative representative remaining. Through the years the Board has included men and women, attorneys, physicians, those active in the political social, and business life of our community, teachers, university chancellors, and previous school system superintendents. The Board has had the benefit of service by government workers, union leaders, bank officers, and insurance executives. These men and women were not only subscribers themselves but at every turn in the road had the subscribers interest first and foremost on their list of sincere concerns.

One staffer suggested that these individuals were well intended public servants not fully appreciating the responsibilities before them. Well intended, yes but nothing could be farther from the truth with regard to responsibilities: Continually in the front of our minds was the charge of the director as a steward and the sense of trustees as *servants* (from a pamphlet provided to all members by the Long Range Planning Committee).

Others have argued that the Board did not exercise diligent oversight or that there was a shortfall in vigilance. Simple hindsight could lead one to jump to that conclusion because problems, now recognized, did indeed develop. If vigilance means being watchful, attentive, and alert to changing circumstances then this Board was vigilant. If diligence consists of a persistent and earnest effort to accomplish its given tasks then this Board was diligent. Attendance at meetings was uniformly high, if not perfect, and wherever possible the sincerity and industry trustees caused them to be patched through even when on vacation, including a record 5-hour telephone call with a director on vacation on one urgent occasion. One trustee came down with acute leukemia, after treatment had a relapse and still over that 2-year period missed only a pair of Board meetings. He attended 8 Committee meetings out of diligence and industry, indeed, attending to the business of committees to which there was no formal assignment or expectation of compensation. We grappled with the data presented in the most responsible way possible while resisting the temptation to assume roles of day to day management and administration, roles which as Board members were not permitted or required to assume.

Mallory Walker's hard to assemble spread sheet showing serious cumulative losses in the subsidiaries and the February Audit Committee's analysis and recommendation, demonstrated the depth of the problems. When confronted with the picture the Executive Committee and the Board moved aggressively and quickly to forge deliberate change. A comprehensive, full depth consultation by McKinsey &

Co. was commissioned by the Board with the expectation of recommendations for substantive revisions of corporate operations. The designation of Benjamin W. Giuliani as the CEO to effect such change was coupled to Board approval of the report. The professional relationship with McKinsey was with the Board itself (and its Long Range Planning Committee), not management. Requests for preliminary reports of matters felt to be of an urgent nature led to an Executive Committee meeting in late July and resulted in Mr. Giuliani assuming the leadership role on July27. Further, the Board has looked to its own role in the new GHMSI and has further reduced its number, revised its bylaws and Committee structure. I will attempt to be as responsive as possible to the questions of the Subcommittee, Mr. Chairman, but I would be hopeful of having the privilege of a summary comment if I might be extended that courtesy. Thank you very much.

PREPARED STATEMENT OF MR. GIULIANI

Mr. Chairman, members of the Committee; my name is Ben Giuliani and since July 27, 1992 I have had the authority of the Chief Executive Officer of Group Hospitalization and Medical Services, Inc. Prior to that time I was the President of GHMSI's principal division, Blue Cross and Blue Shield of the National Capital Area, for nearly 4 years. I want to thank you Mr. Chairman for this opportunity to appear today to respond to questions that have been raised about our business and the changes which have occurred in the past several months.

GHMSI has prepared a much longer statement, which sets forth in detail our responses to a variety of specific concerns raised during yesterday's hearings and in the media during the past several months. I will not read from that document but I respectfully request that it be incorporated as part of the record in these hearings.

In the mid to late 1980s, the traditional role of health insurers began evolving rapidly. The staggering increases in medical costs required, in order to best serve subscriber needs, that GHMSI develop new and better solutions to the increasingly complicated problems encountered in connection with our data processing systems. To that end, GHMSI invested heavily in developing new claims processing technology.

The FLEXX system which resulted from that effort, has been an extraordinary success. Because of the flexibility and efficiency gained through the implementation of the FLEXX system, BCBSNCA is able to pay 90 percent of its claims within 14 days and resolves over 90 percent of all telephone inquiries within 2 business days. Likewise, BCBSNCA has reduced administrative costs from 13.4 percent in 1986 to 8.2 percent by 1991.

That, however, was not the only customer specific response required by the changing competitive environment. In addition to matching products offered by competitors, including, for example, life insurance, the pressure was intense for BCBSNCA to become increasingly engaged in managing the cost and quality of medical care.

In addition to meeting these competitive demands within the core business, GHMSI also sought through a diversification strategy to reduce the competitive impact of down cycles customary within the industry. The well-intended purpose of diversification was to increase revenues and profits with which to support the core business during cyclical downturns as well as to expand GHMSI's markets beyond the tightly constricted, highly competitive geographic area in which it operates.

While much of the diversification effort was responsive to customer needs including, for example, CapitalCare, our successful HMO, or was necessary to meet competition, such as providing life insurance and certain other products, unfortunately, many of the subsidiary endeavors initiated by GHMSI, particularly in the international area, have proved unsuccessful.

In early 1992, as the year end 1991 financial results were being compiled, the realization that GHMSI's overall subsidiary operations would be responsible for yet another sizable unanticipated loss, some within the organization, including myself, voiced concerns about the direction of the company.

The Board, having been previously and repeatedly assured by former management that the subsidiaries were turning the corner and expected to be profitable, understandably ran out of patience and initiated a critical self-examination of the company designed to review and address operations across the board.

McKinsey & Company, a very capable and reputable consulting firm, was brought in and assigned the task of this massive operational review. McKinsey was also asked to assist in advising the Board in connection with the elimination and/or sale of underperforming or unnecessary subsidiary operations—a task to which the

Board has become absolutely committed and one to which I have dedicated my efforts since assuming my current responsibilities on July 27,1992.

It is important that you and the public understand, Mr. Chairman, that before agreeing to become CEO and as early as February, 1992 I offered to leave GHMSI if my 30 years within the enterprise was seen as an obstacle either to the important changes required or to the pace at which they could be achieved. Please do not be under the misimpression that I view myself as blameless for the situation I inherited upon becoming CEO. Likewise, please understand how grateful I have been for the opportunity to confront and seek solutions to the difficulties faced by the organization to which I have devoted my professional life.

GHMSI's internal review coupled with the heightened scrutiny attendant to the efforts of this Subcommittee have produced radical changes within our organization. Pursuant to our new strategic plan emphasizing a return to focusing on meeting the needs of the metropolitan D.C. area subscribers through our core business, as CEO, I have authorized the sale or elimination of 24 of the 45 subsidiaries which existed on the day I took office. I have targeted up to ten others for sale or elimination this year.

Management and financial controls on the subsidiaries were implemented aggressively. The rosy financial projections routinely received from subsidiary executives in the past were no longer tolerated. While many foreign subsidiaries had no place in a restructured GHMSI, decisions on other subsidiaries required careful financial analysis. Accurate financial reporting from those subsidiaries was critical to my mission of determining which were either underperforming or unnecessary to support the core business.

In the first minutes of my tenure, I eliminated problematic travel and expense policies. Other priorities included staff reductions starting at the top. Officer positions were reduced by nearly 25 percent. A hiring freeze was instituted within the organization. Reigning in costs and expenses has been emphasized successfully.

Another important effort involved mending relations with certain of our regulators and our national association by emphasizing within GHMSI the importance of being responsive to their informational needs. Enforcing this directive required difficult personnel and related actions.

Despite the time and resources required by regulatory issues which persist in Virginia, GHMSI has succeeded in sharply defining and dealing with the reality of our balance sheet by (1) abandoning the broader diversification strategy which had resulted in troubling losses, (2) focusing on the core business, and (3) emphasizing only those subsidiaries which are necessary to support the core business. That effort has enabled us to develop a comprehensive business plan for 1993 that GHMSI believes will result in adding $13.6 million to its reserve levels this year.

In addition, GHMSI is pursuing the option of an affiliation with Blue Cross and Blue Shield of Virginia. Such an affiliation holds great potential for this area. The combined entity could be a major force in the region and provide substantial subscriber and customer benefits in the highly competitive and challenging era of managed care.

Those discussions are at a sensitive yet constructive stage. In the affiliation discussions, GHMSI's priorities are the interests of its subscribers, employees and providers. The multiple regulators whose support will be important to the affiliation are critical to the process.

It is the hope of GHMSI that with a cooperative, constructive and responsible approach by the regulators, either through the affiliation or otherwise, GHMSI's restructuring efforts and its demonstrated commitment to those efforts will enable GHMSI to extend its 60 years of dedicated service to this community.

STATEMENT OF GROUP HOSPITALIZATION AND MEDICAL SERVICES, INC.

Presented to the U.S. Senate Permanent Subcommittee on Investigations of the Committee on Governmental Affairs

Submitted on January 25, 1993 by Hogan & Hartson, 555 13th Street, N.W., Washington, DC 20004, Counsel to GHMSI.

EXECUTIVE SUMMARY

This written statement is submitted on behalf of Group Hospitalization and Medical Services, Inc. ("GHMSI") and accompanies the testimony of Benjamin W. Giu-

liani, President and Chief Executive Officer ("CEO") of GHMSI. It is intended to address the principal issues of interest to the Permanent Subcommittee on Investigations of the Senate Governmental Affairs Committee in connection with hearings on January 26 and 27, 1993. Set forth below are some of the key issues highlighted in this statement.

1. *The hearings are scheduled at a critical time for GHMSI.* This statement candidly addresses GHMSI's current financial condition, regulatory posture and intentions for the future. GHMSI has been engaged in sweeping management and operational changes which have slashed costs and expenses and achieved the sale or elimination of 24 of GHMSI's 45 subsidiaries. GHMSI is in the midst of sensitive yet constructive discussions with Blue Cross and Blue Shield of Virginia ("BCBSVA") exploring the possibility of a broader affiliation between the two organizations for the purpose of better serving health insurance subscribers in the D.C. metropolitan area. The combined entity would be the third largest Blue Cross and Blue Shield Plan in the country and, through the economies of scale achieved by affiliation, could play a major role in the effort to provide reasonably priced health insurance in this region as the challenging and competitive era of managed care evolves.

2. *GHMSI's current financial strength.* GHMSI is meeting its obligations to subscribers and providers.

- GHMSI has in excess of $90 million in cash or liquid securities and over $300 million set aside on its balance sheet against unpaid claims.
- GHMSI's statutory reserves far exceed present requirements in both Maryland and the District of Columbia. GHMSI is engaged in ongoing discussions with the Virginia Bureau of Insurance concerning compliance with Virginia reserve requirements.
- The Virginia Bureau of Insurance's current interpretation of its own statutory reserve requirement makes it one of the most stringent in the Nation. GHMSI has taken concrete steps to meet the requirements of the Virginia Bureau, including the purchase of reinsurance for certain Virginia subscribers and the addition of $15 million to statutory reserves through a surplus note from the Blue Cross and Blue Shield National Association (the "Association").
- The improved business atmosphere at GHMSI has enabled GHMSI to produce a business plan for 1993 which projects revenues of approximately $1.7 billion and an increase in statutory reserves of approximately $13.6 million.

3. *GHMSI compares favorably to other Blue Cross and Blue Shield Plans across the Nation in customer service.* While every business has some dissatisfied customers, GHMSI takes its customer service obligations very seriously and, based on statistics compiled by the Association, has a good record of customer satisfaction.

- GHMSI pays 90 percent of its claims within 14 days.
- GHMSI resolves over 90 percent of all telephone inquiries within 48 hours.

4. *GHMSI's diversification strategy.* In order to meet competition and in an effort to soften the impact of cyclical downturns common in the industry, in the mid-1980s GHMSI invested heavily and successfully in state-of-the-art claims processing technology; it also sought to increase sources of revenue and lower administrative costs through expanding subsidiary operations beyond the tightly constricted geographic region to which GHMSI is limited.

- Many subsidiaries supported GHMSI's core business of providing health insurance in the D.C. metropolitan area, including, for example, GHMSI's HMO, CapitalCare, which is expected to post a $4.5 million profit for 1992.
- Numerous subsidiaries, however, have proven to be unsuccessful.
- Despite the hope and expectation that initial subsidiary losses were short-term results attributable to start-up costs, and despite having received repeated assurances from GHMSI's former CEO that subsidiary operations would be improving, following substantial losses by the subsidiaries in 1991, GHMSI's Board of Trustees initiated a critical self-examination which accelerated the transition of management responsibilities from GHMSI's former CEO to Mr. Giuliani on July 27, 1992.
- Since late July, under Mr. Giuliani's leadership, GHMSI has sold or eliminated 24 of its 45 subsidiary operations and has targeted up to 10 others for elimination in 1993.
- GHMSI's business focus at this stage is to return to its core business, Blue Cross and Blue Shield of the National Capital Area, and to maintain only those subsidiaries necessary to support that core business.

5. *Other changes at GHMSI.* Upon assuming the responsibilities of CEO last July, Mr. Giuliani:

- eliminated problematic travel and expense policies;
- reduced the number of corporate officers by nearly 25 percent;
- imposed a hiring freeze which has subsequently assisted in reducing GHMSI's work force;
- imposed tight management and financial controls on the subsidiaries; and
- slashed costs and expenses throughout the organization.

6. *GHMSI's Board of Trustees is a dedicated group of individuals mindful of their responsibilities to serve the best interests of GHMSI's subscribers.* While issues may arise with respect to Board oversight and the activities of the Board, particularly in light of the allegations of self-dealing and other improprieties with regard to the Board of the failed West Virginia Plan, this Statement discusses:

- the extent to which the Board was guided by GHMSI's former CEO in connection with his diversification strategy;
- the minutes of Board meetings which demonstrate the former CEO's strong belief in the wisdom and ultimate success of that strategy;
- the Board's action in abandoning the diversification strategy when it became convinced that the substantial losses which had resulted from that strategy could no longer be tolerated and that the former CEO's assurances of the future profitability of subsidiary operations were unfounded;
- the Board's support for Mr. Giuliani's sale or elimination of subsidiaries and renewed emphasis on the core business; and
- the Board's support for the discussions currently underway between GHMSI and BCBSVA as an opportunity to well serve subscriber needs in the region.

The turn-around efforts initiated by GHMSI in early 1992, in combination with the subsequent scrutiny of the Permanent Subcommittee on Investigations, has helped GHMSI to refocus on its mission of fulfilling the interests and needs of its subscribers. As GHMSI pursues the affiliation with Virginia, it is negotiating with the interests of those subscribers, as well as GHMSI's employees and providers, well in mind. Whether or not that affiliation is consummated, the appropriate business culture has been restored at GHMSI. Following the chastening experience of the past few years, GHMSI, through renewed emphasis on the core business and with the vigilance and cooperation of its regulators, will continue to be a dedicated contributor to the community it has served for over 60 years.

I. Introduction

This statement is the product of a critical self-examination initiated by Group Hospitalization and Medical Services, Inc. ("GHMSI") in early 1992 which, in combination with the subsequent scrutiny of the Permanent Subcommittee on Investigations of the Senate Governmental Affairs Committee, has helped GHMSI and its Board of Trustees to identify and achieve many significant structural and operational changes and to focus on the important work that remains. GHMSI has cooperated fully and completely with the Subcommittee in the course of its analysis by providing and organizing over 65,000 pages of documents and by voluntarily providing dozens of current and former GHMSI officers, directors and employees for interviews by the Subcommittee Staff.

These hearings come at a critical juncture in the corporate history of GHMSI. As indicated above, the year 1992 produced radical changes within GHMSI. A complete change in business strategy was accompanied by numerous personnel changes. Although the core health insurance business continues to perform adequately, both financially and in quality of service, the problems created by the poor financial performance of certain subsidiaries have taken their toll. Adverse publicity, intensified by the investigation leading to these hearings, and the differing approaches of interested insurance regulators have combined to create the most difficult business climate that GHMSI has ever confronted in its nearly 60 years of service to the community. GHMSI has devoted considerable time and resources over the past 11 months to an effort to identify the problems, and it has developed a meaningful business plan for moving forward. As with any other major overhaul of a corporation, the full effect of the remedial measures will not be fully apparent for some time. Moreover, the effectiveness of GHMSI's efforts depends, in part, on the extent to which these hearings assist in fostering a constructive approach by all concerned parties.

The process by which GHMSI has come to chart a new course has been a chastening experience for the enterprise and its trustees, officers and employees. Some of the facts that have come to light have been embarrassing to an organization that has always prided itself on its commitment to the public. Nevertheless, GHMSI has chosen to deal with the hearing process in an honorable and candid way. In this testimony, GHMSI acknowledges responsibility for many of the problems that confront it today. Mistakes unquestionably were made. Nevertheless, for this process to be truly constructive it must do more than simply identify the problems. It also must help identify solutions.

This testimony therefore identifies the concrete steps that GHMSI has taken to address the problems in order to assure the continued protection of its subscribers. GHMSI remains absolutely committed to serving the Washington, D.C. metropolitan community. GHMSI is paying claims in full and in a timely fashion. GHMSI currently has in excess of $93 million in its investment portfolio, over $300 million set aside on its balance sheet as a reserve for unpaid claims and statutory reserves of $48.4 million.[1] In addition, GHMSI has developed a detailed business plan that projects in 1993 revenues of $1.7 billion and a net addition to statutory reserves from operations of $13.6 million.

Since July 27, 1992, when Benjamin W. Giuliani assumed the responsibilities of Chief Operating Officer of GHMSI, having previously served as President of GHMSI's core business, Blue Cross and Blue Shield of the National Capital Area ("BCBSNCA"),[2] the strategic direction and corporate culture at GHMSI has changed. Among the most important initial steps taken by Mr. Giuliani were the implementation of new management and financial controls which, among other things, prohibited subsidiaries from expanding into new lines of business, and the adoption of a corporate policy forbidding first-class travel and certain other discretionary expenses. Hiring throughout the organization was frozen. GHMSI has reduced its officer ranks by almost 25 percent. GHMSI terminated an account used to record corporate expenses, including first-class travel. That account, while a legitimate accounting mechanism, had encouraged certain types of executive expenses that were inconsistent with the new policy on expenses. Audits have been ordered of the travel and entertainment expenses submitted by all officers. Efforts have been made to assure more responsive and accurate financial reports to all regulators and the Association. Moreover, in the last 5 months of 1992, GHMSI sold or eliminated 24 of its 45 subsidiaries; it intends to sell or eliminate up to 10 more in 1993. Only those subsidiaries absolutely necessary to support BCBSNCA will remain, including for example CapitalCare, GHMSI's HMO, which expects to post a profit of more than $4.5 million for 1992.[3]

II. Background

Few businesses in America have experienced more turmoil and difficulty over the past 10 years than those in the health insurance industry. Competition has been fierce; the regulatory climate has changed constantly; the cost of health care has increased exorbitantly; and consumer expectations have constantly risen. Major commercial insurers have abandoned huge investments and withdrawn from the market, or specific segments of it. Everyone agrees that the current system of reimbursing for health care has grave problems, but there is little consensus on solutions. It was not always so complicated.

GHMSI traces its origins to 1934—the depth of the Great Depression. In those times, people of moderate means found it practically impossible to pay for hospitalization. Group Hospitalization, Inc. ("GHI") was formed to respond to that need through the mechanism of a prepaid hospitalization program. For 75 cents a month, a covered employee was entitled to 21 days of hospital care each year. From its inception, GHI considered its critical mission to be serving its subscribers. Indeed, GHI became congressionally chartered in response to an effort to require it to be reorganized as a stock or mutual insurance company, a structure that the organization perceived to be inconsistent with its nonprofit character. Over the ensuing years, GHI became the designated Blue Cross Plan for the Washington, D.C. metro-

---

[1] This figure includes a $15 million surplus note from the Blue Cross and Blue Shield Association (the "Association") and it could be subject to adjustments depending on the resolution of pending statutory accounting issues.

[2] As used in this Statement, the term "BCBSNCA" refers to the core health insurance business, including CapitalCare, a health maintenance organization ("HMO").

[3] Attached hereto as Appendix A is a chart explaining GHMSI's reorganization.

politan area and the scope of its coverage continued to expand in response to subscriber demand.

GHI became GHMSI in 1985 upon merging with Medical Service of the District of Columbia ("MSDC"), a Blue Shield Plan offering prepaid coverage for certain physician services that had operated in the area since 1948. GHI had always worked closely with MSDC, and the formal combination of GHI and MSDC reflected a national trend toward the merger of Blue Cross and Blue Shield Plans. Congress amended GHI's charter in 1984 to allow the merger under the corporate name Group Hospitalization and Medical Services, Inc. The amended charter confirmed GHMSI's status as a non-profit organization, directing that the corporation "be conducted for the benefit of the [subscribers]." Since January 1985, GHMSI's core insurance business has operated under the trade name "Blue Cross and Blue Shield of the National Capital Area."

The merger that resulted in GHMSI provided advantages to the subscribers of both Plans by creating a more efficient corporate structure. At the same time, by 1985 it was obvious that more than simply a consolidation of Blue Cross and Blue Shield operations would be necessary if GHMSI was to continue meeting the public's expectations. When GHMSI first began to operate, health insurance was not a typical employee benefit and the scope of coverage was limited. Over the ensuing years, employers began to offer health insurance with greater frequency because of its low cost and universal appeal. As the benefit became more popular, subscribers demanded a wider range of services. For decades, the cost of health insurance remained relatively stable; because Blue Cross and Blue Shield Plans relied primarily on a community rating approach to setting rates, it was possible to spread the risk over a large number of subscribers.

The landscape began to change dramatically about 15 years ago. Competition from commercial insurance companies became more intense and HMOs began to grow in popularity. One advantage that the commercial insurance companies enjoyed was the ability to select their risk pools by focusing on the more profitable segments of the community, typically the suburbs. Although this practice usually reduced the cost of insurance for a particular account, it placed BCBSNCA, the insurer of last resort, at a competitive disadvantage. Increasingly, younger, healthier people chose less costly products like HMOs rather than the traditional insurance products offered by BCBSNCA. That trend was particularly notable in the Washington, D.C. area because of the constant flow of young people moving to the community.

Despite these competitive pressures, BCBSNCA managed to maintain a significant, although diminished, presence in the metropolitan D.C. market; in 1992 it covered approximately 28.7 percent of the market, still more than double the percentage served by its nearest competitors. Unfortunately, BCBSNCA experienced a decline of almost 50 percent between 1986 and 1991 in its accounts covering groups with fewer than 50 people, a category that historically had contributed to the accumulation of reserves. Today, fully insured (risk) business makes up only about 20 percent of BCBSNCA's business. Forty percent of its business consists of the provision of administrative services only for local and national accounts and the remaining 40 percent consists of BCBSNCA's participation in the Federal Employees Program ("FEP"). The proportion of BCBSNCA's business devoted to the FEP is the largest for any Plan in the country. Notwithstanding these changes in the composition of its business, BCBSNCA has continued to function as the insurer of last resort in metropolitan D.C., offering insurance to those segments of the public spurned by commercial insurers.[4] BCBSNCA has never been accused of "red-lining" health insurance coverage by favoring the suburbs over the District of Columbia; it serves the *entire* community.

GHMSI's location also worked against it. The license from the Association prohibits GHMSI from soliciting any accounts in Virginia south of Route 123. That prohibition became a significant barrier as accounts migrated from D.C. to the Virginia suburbs. GHMSI's activities in Maryland were likewise limited, as a practical matter, to Montgomery and Prince George's counties. Overall, 39 percent of GHMSI's subscribers live in the District, 29 percent live in Maryland, and 23 percent live in Virginia. In terms of risk business only, 41 percent live in the District, 32 percent live in Maryland, 26 percent live in Virginia.

Another marketplace problem arose from the effect of underwriting cycles. For some time, BCBSNCA, and the health care industry as a whole, has experienced 6-

[4] BCBSNCA offers open seasons twice a year in D.C. and Maryland and continuously in Virginia. While the Maryland and Virginia open seasons are mandatory, BCBSNCA voluntarily permits open seasons in the District.

year cycles of increased and decreased profitability. Sharply increasing health care costs in a highly competitive and contractually restrictive market fueled the cycle: because competition restrained rate increases and the rates were traditionally set on an annual basis, premium income could not keep pace with the costs, Particularly at a time when health care costs were accelerating. Furthermore, within each 6-year cycle, the losses during the "down-phase" were becoming deeper, while the profits in the "up-phase" were flattening.

By the mid-1980s the effects of these marketplace trends had, justifiably, become a major concern for GHMSI. At the beginning of the last loss phase in 1986, GHMSI's reserves, calculated according to generally accepted accounting principles ("GAAP"), were $180 million. In 1986, 1987 and 1988 the underwriting activities of the core business generated losses, respectively, of $50.4, $58.5 and $17.7 million.

Apart from underwriting losses, another cause of the decrease of reserves was the tremendous cost of installing new data processing capabilities. Between 1984 and 1988, GHMSI spent nearly $60 million on research and development costs, primarily for the development and implementation of the FLEXX Claims Processing System. The creation of a modern data processing system was absolutely critical to GHMSI's ability to satisfy its customers and compete in the marketplace. Some Plans have been criticized for wasting millions of dollars on new data processing programs that either do not work or cause conflicts with existing systems. The development of new data processing and information systems is a daunting challenge for any health insurer, but, by all accounts, BCBSNCA has skillfully managed the introduction and modification of FLEXX. The FLEXX System has, for example, enabled BCBSNCA to meet, and in many cases to surpass, the goals of paying 90 percent of all claims within 14 calendar days of receipt and resolving over 90 percent of all telephone inquiries within 2 business days.

The movement toward managed care has also required an intensive investment in information technology. Managed care will play a vital role in BCBSNCA's future development: Managed care benefits subscribers by providing quality care at a lower cost and benefits insurers by providing greater control over the cost of services, thus diminishing one of the critical forces driving the down cycles. Unfortunately, unlike its private competitors, GHMSI does not have access to-the-capital markets to finance its investment in data processing. Reserves must be used to pay for the investment.

The combined effect of underwriting losses and the huge investment in data processing caused GHMSI's reserves, on a GAAP basis, to decline to $15,733,000 by the end of 1988, a decrease of more than $160 million since the beginning of 1986.

Confronted with so many issues in its core business, GHMSI was urged by its President and CEO, Joseph P. Gamble, to diversify its business activities to develop sources of income that were not subject to the same underwriting cycles. Diversification was a logical response to the changing dynamics of the market. Given the growing popularity of HMOs, GHMSI faced the loss of significant accounts if it could not include an HMO in its plan options. The emergence of third-party administrators and utilization review companies, many of which were owned by competitors, created a threat to GHMSI's core business that could not be ignored; development of such products was critical for preserving valuable customer relationships. In addition, the brokers who marketed GHMSI's products insisted that other insurance products, such as life and disability insurance, be made available. And, finally, by pursuing nation-wide and international opportunities, GHMSI hoped to develop subsidiaries that would not be shackled by the geographic constraints imposed on the core business. In short, through the development of subsidiary operations, GHMSI hoped not only to create a buffer from the underwriting cycles, but also in some cases to complement the operations of the core business.

There can be a legitimate debate about the wisdom of a diversification strategy. A legion of businesses have benefited greatly from diversification in precisely the ways contemplated by GHMSI. Indeed, many Blue Cross and Blue Shield Plans in the country currently have successful subsidiary operations. Moreover, it is difficult to see how BCBSNCA could be an effective competitor today without a viable HMO or the ability to market complementary insurance products. What cannot now be debated is that GHMSI's execution of its diversification strategy was unsuccessful.

As a result of a comprehensive internal review process that began in February 1992 and the heightened self-examination prompted by this hearing process, GHMSI has substantially restructured its operations and strategy. The focal point of the new enterprise is the core business; in order to best serve subscribers, GHMSI will

retain only those subsidiaries that complement the products and services offered by BCBSNCA.[5]

III. Diversification

Mr. Gamble, the company's former CEO, devoted 35 years of his life to GHMSI and was the architect of the diversification strategy. Specifically, he envisaged that GHMSI could build upon its presence in Washington D.C., a focal point for national and international activity, to become a national and international force in the delivery of health care benefit programs.

Mr. Gamble was a persuasive advocate of his vision. In meeting after meeting of the Board of Trustees, he reported on the progress of the subsidiaries and reiterated his conviction that diversification was absolutely critical to the future success, if not the survival, of GHMSI. Mr. Gamble's remarks at the March 8, 1988 GHMSI Board meeting reflect his views:

> Dr. Speck commented that he did not wish to be negative, but noted that in a recent newspaper article, the Virginia Insurance Department expressed concerns regarding BCBSNCA's subsidiaries and reserve levels. He stated that based upon projections presented in this report, the subsidiaries may be in the black in 1989, but noted that it may take 5 or more years to recoup the losses. Dr. Speck noted that Blue Cross and Blue Shield organizations started out as health insurance organizations. He stated that since the board has been informed about the expansion into areas which he feels are not expanding the core business, he is concerned with BCBSNCA's future. Mr. Gamble stated that BCBSNCA has invested a total of $3.5 million in its subsidiaries, and, as he previously stated, *he believes that these subsidiaries are a survival issue. He stated that there has been a gradual deterioration of Blue Cross and Blue Shield enrollment and that these subsidiaries are needed in order for BCBSNCA to survive in the future. Dr. Speck commented that BCBSNCA may not survive. Mr. Gamble responded that these subsidiaries will permit BCBSNCA to survive.* (Emphasis added).[6]

Given Mr. Gamble's many years in leadership roles within the organization, the Board naturally placed considerable trust and confidence in his business judgment and management skills.

As the number of subsidiaries increased, Mr. Gamble increasingly devoted more of his attention to GHMSI's diversification effort, entrusting the operation of the core business—BCBSNCA—to Mr. Giuliani. With the development of international ventures, Mr. Gamble travelled more frequently, often being absent from the office for weeks at a time. The division of responsibility was formally recognized by a 1988 reorganization that established BCBSNCA as a separate division, with its own advisory board, under the direction of Mr. Giuliani. Although each of the subsidiary corporations had a board of directors, typically headed by Mr. Gamble, in reality those boards were nothing more than a legal formality. Mr. Gamble exercised strong control over the subsidiaries, seeking virtually no consultation from the officers running the BCBSNCA operations. Mr. Gamble's reports to the Board concerning the subsidiaries emphasized the opportunities and the visionary aspects of GHMSI's expansion.

A number of observations can be made concerning the subsidiaries, particularly those that did not directly complement the core business. Too often, GHMSI embarked upon subsidiary ventures without a comprehensive understanding of the business, a clearly defined business strategy, or objective management criteria for measuring whether the subsidiary was meeting its purpose. The results of those

---

[5] Attached to this Statement as Appendix C is a detailed discussion of each operating subsidiary and some of the issues that have been raised by the Subcommittee Staff.

[6] This was only one of several instances in which Mr. Gamble made presentations to the Board emphasizing the importance of diversification for protecting the core business. Mr. Gamble also regularly expressed his view that losses at the subsidiaries did not require any change in GHMSI's overall direction. For example, in March of 1990 Mr. Gamble informed the Board that despite subsidiary losses in 1989 for Blue Cross of Jamaica, the Insurance Group and the Special Services Group, he expected most subsidiaries would show gains instead of losses in 1990. Regrettably, GHMSI's subsidiaries suffered a net loss of $13.1 million in 1990. When asked to address those losses at a Board meeting on March 12, 1991 Mr. Gamble attributed them principally to problems with a limited number of subsidiaries and advised the Board that net profits were anticipated from the combined operations of the subsidiaries in 1991 and 1992. Substantial losses occurred in both years.

shortcomings were business failures such as Protocol, NCRe,[7] and the Assistance Group.

Although new businesses typically lose money at their inception, GHMSI never developed a system for rigorously evaluating subsidiary performance and eliminating those subsidiaries that showed consistent losses with little prospect of profitability. This failing can be attributed to the absence of adequate management tools. Financial reporting for the subsidiaries was inadequate for an enterprise of GHMSI's size. Particularly in 1990 and 1991, reports to the Board indicating that the subsidiaries had "turned the corner" were later amended at year end to show dramatic losses. The need to improve accountability for variances between actual and projected operating results became clear. The inability to resolve that problem continued to plague the enterprise, however, until as late as the first quarter of 1992.

Beyond the absence of adequate financial controls to monitor subsidiary performance, it is now apparent that Mr. Gamble experienced difficulty in selecting the right people to operate the subsidiary businesses. People often were transferred from a Blue Cross and Blue Shield job to start up one of the subsidiaries or, in a few instances, they were hired from the outside without the requisite business expertise and management skills to operate a new business. The lack of expertise in the area of actuarial work ultimately proved to be a serious problem. There were, of course, exceptions: for example, E. Seton Shields (President of Health Management Strategies International, Inc.), Peter R. Kongstvedt (former President of CapitalCare), and David L. Ward (President of CapitalCare) achieved notable successes. The usual result, however, was that GHMSI attempted to operate complicated businesses with management that, as it turned out, did not fully understand the businesses or what it would take to succeed.

The deficiencies in management were further exacerbated by the absence of adequate management controls. Historically, BCBSNCA had emphasized the need to reduce administrative expenses as a percentage of claim revenue. Beginning as early as 1986, the core business sought to cut costs by eliminating jobs, consolidating operations, and reducing overhead. Those efforts, championed by Ben Giuliani, succeeded in substantially lowering BCBSNCA's administrative cost ratio from 1986 to 1991. By contrast, certain subsidiaries devoted virtually no attention to budgeting or controlling costs. There was no chief financial officer for the organization as a whole with authority to regulate subsidiary costs. Mr. Gamble was the only GHMSI officer with general oversight responsibility for the subsidiary operations, and he was committed to expanding revenues, not to limiting expenses. As a consequence, the subsidiaries exercised wide latitude in authorizing employee costs, such as travel and entertainment, or undertaking new lines of business.

Certain subsidiaries and groups, Protocol and the Insurance Division being particularly notable, spent lavishly on dinners and corporate sponsorships. Often the expenditures bore no relationship to the success of the subsidiary or even to the profitability of the customer account being entertained. For example, in early 1992 Protocol sponsored an expensive trip to Hawaii purportedly to promote good relations with B'nai B'rith, Protocol's largest account. Yet that account has been the source of substantial losses for GHMSI. Such spending habits also affected business travel. Mr. Gamble believed that all GHMSI executives should, as a matter of policy, travel first-class and some, including Mr. Gamble, became frequent fliers on the Concorde. These travel practices were not common in BCBSNCA.

The issue of excessive expenses is ultimately a matter of perspective. Unquestionably, the absence of controls wasted money. But the incremental cost of upgrading to first-class or flying the Concorde, or even of sponsoring the Hawaii trip, is small as a percentage of GHMSI's overall expenses—in accounting terms, it is not "material." Those expenditures in themselves did not cause GHMSI's financial problems. Concededly, however, they were inconsistent with the financial performance of the subsidiaries and, more importantly, with GHMSI's mission of operating for the benefit of its subscribers. Executives for fledgling businesses that are losing substantial amounts should not fly first-class. Such spending practices sent the wrong message to the overall enterprise and were halted immediately upon Mr. Giuliani's assumption of his duties as Chief Operating Officer on July 27, 1992.[8] Indeed, the lack of

---

[7] As explained more fully in Appendix A, in 1987, GHMSI formed National Capital Reinsurance, Inc. of Barbados to provide reinsurance to outside clients as well as many of GHMSI's subsidiaries. National Capital Reinsurance Ltd. of Ireland was created in 1991 for the same purpose. Throughout this Statement, these two companies will be collectively referred to as "NCRe."

[8] Although Mr. Giuliani's formal position on July 27, 1992 was Chief Operating Officer and President-elect of GHMSI, he was authorized to exercise all the responsibilities of CEO begin-

Continued

controls apparently fostered the belief within certain subsidiaries that there was a limitless supply of money and that the challenging business climate in which they operated was somehow free of risk.

Another now obvious problem in the subsidiary operations was the extent of due diligence in advance of GHMSI commitments. The experiences with Blue Cross of Jamaica and Access America illustrate this problem, although in different ways. In the case of Blue Cross of Jamaica, GHMSI invested $5 million without a detailed study of the economic and political climate in Jamaica, or the true financial situation of the company. Additional complications, such as the impact of foreign currency transactions on GHMSI's financial statements and the difficulties of liquidating the investment, were not fully explored.

GHMSI's decision in August 1990 to acquire the Empire Plan's share of Access America presents a different situation. GHMSI had owned a 40 percent interest in Access America since Access America's creation in 1984. Access America marketed travel assistance products and GHMSI's World Access subsidiary provided complementary international assistance services. At the time of GHMSI's acquisition of the Empire Plan's 60 percent ownership interest in Access America, its primary underwriter was threatening to cancel coverage and there were known problems at a major account. Moreover, it appears that no audited financial statements for 1989 were available when the transaction was being contemplated in the summer of 1990. Although the decision to purchase the Empire Plan's share of Access America has been justified as being necessary to preserve GHMSI's investment in World Access, GHMSI can be fairly criticized for considering more seriously whether that objective made business sense in view of the problems at Access America. Once GHMSI took over, it became apparent that Access America had staggering problems: In 1990 and 1991 alone GHMSI suffered losses of over $26 million on the assistance business.

All of these deficiencies were magnified by the sheer scope of GHMSI's ambitions under Mr. Gamble's leadership. In less than 5 years, GHMSI was transformed from an organization focused on D.C. with a single basic business to one with multiple subsidiaries and business interests around the world. As the result of the critical self-examination in which GHMSI has been engaged for almost a year, it now must be conceded that GHMSI simply did not have in place a management structure capable of operating such a far-flung undertaking. Indeed, Mr. Gamble's passion for creating an international health insurance network obscured the importance and impact of practical considerations. The costly, and ultimately unsuccessful, confrontation with the Association over the international use of the Blue Cross trademark is illustrative. That dispute not only wasted millions of dollars in legal fees and created a logistical nightmare when the case was lost, but it also understandably adversely affected GHMSI's relationship with the Association.

Despite Mr. Gamble's years of loyal service and many notable accomplishments, the effort to expand GHMSI through diversification and the related emphasis on increasing subsidiary revenues, in the final analysis, have been a failure. Concededly, too many of GHMSI's new enterprises ultimately failed to advance GHMSI's mission of operating for the benefit of its subscribers. For that reason, diversification as envisioned by Mr. Gamble has been abandoned as a corporate strategy and renewed attention to the core business and those few subsidiaries critical to its mission are now the order of the day.

IV. Board Action

Obviously, with the benefit of hindsight, there is much to criticize in GHMSI's diversification effort. But any fair evaluation of the Board's performance must consider the fact that Board trustees, by necessity, must focus on broad policy issues and cannot immerse themselves in the details of day-to-day management. The established legal standard for assessing the decisions of fiduciaries such as Trustees is whether they acted in good faith and exercised independent business judgment—the so-called "business judgment rule." The business judgment rule recognizes that directors cannot predict the future and must rely on information supplied by management. That well-intentioned business plans were not realized does not mean that the Trustees somehow acted improperly; it is not at all unusual for corporations to change their business strategy and restructure their operations in response to unacceptable business reversals.

In fairness, moreover, the situation seemed much different as it evolved. The desirability of softening the business cycles associated with the core business was clear

---

ning on that date. He became President and Chief Executive Officer upon Mr. Gamble's retirement on November 12, 1992.

to everyone, and the subsidiaries certainly appeared to offer a way to accomplish that objective. Losses were anticipated during the initial years of operation, but the subsidiaries were expected to be contributing to reserves by the next down-cycle. Moreover, Mr. Gamble himself considered the losses in the subsidiaries to be short-term growing pains and he continued to dedicate himself to long-term expansion plans. Upon his retirement, Mr. Gamble remained absolutely convinced that his approach was sound.[9]

In early 1990, it appeared that the diversification effort was on track. Price Waterhouse's audit for fiscal 1989 showed that subsidiary losses had been reduced nearly 50 percent from fiscal 1988 and the Board was advised at its March 1990 meeting that most, if not all, of the subsidiaries would be profitable in that fiscal year. By the fall, however, the tone had changed and the optimism about subsidiary profitability had faded. At a Board Meeting in November 1990, certain Trustees expressed concern about subsidiary losses, but Mr. Gamble advised them that 1990 had been an unusual year because of the losses associated with the acquisition of Access America. He noted that the other subsidiaries had broken even on a combined basis, so the business strategy remained sound. A similar pattern occurred in 1991. When the audited financial statements for fiscal 1990 were presented to the Board in March 1991, the results were described as evidence that the subsidiaries were turning the corner, and Mr. Gamble predicted that there would be a net profit from combined operations of the subsidiaries in 1991 and 1992. In November 1991, Mr. Gamble advised the Board that he expected a loss from the subsidiaries of $8 million, which he attributed to an actuarial miscalculation in the case of Protocol and continuing problems arising from Access America's entanglement with American Leadership Study Groups, an insolvent group tour operator. Notably, two of the recommendations from Price Waterhouse in its 1991 management letter, issued in early 1992, focused on the need for improved financial reporting to the Board.

The release in February 1992 of the Price Waterhouse audited financial statements for fiscal 1991 marked a watershed for GHMSI. Those financial statements showed losses on subsidiary operations in excess of $21 million, an amount that not only significantly eclipsed the losses projected toward the end of 1991 but also bore no relationship to the earlier projections of profitable operations. The Audit Committee of the Board, chaired by Trustee David S. Wiggin, recognized that the same path, with the same leadership, could no longer be followed. The report of the Audit Committee prompted a wide-ranging debate within the GHMSI Board at the March 1992 meeting, ultimately leading to the Board's retention of McKinsey & Company, an internationally recognized consulting firm, to provide an independent and objective evaluation of GHMSI's diversification strategy. The Board directed McKinsey to review each of GHMSI's subsidiaries and to make recommendations about whether those subsidiary operations should be maintained within the GHMSI enterprise.[10] In late July 1992, Mr. Gamble ceased all active management of GHMSI.

V. Development and Implementation of GHMSI'S Business Plan

In its analysis for the Board, McKinsey considered each subsidiary's profitability, or ability to become profitable, its ongoing capital needs, the outlook for the particular business, the capabilities of its employees, and its strategic relationship to the core business. With the benefit of the McKinsey review, current management is eliminating 24 subsidiaries. Among the operating subsidiaries which have been or are in the process of being closed are International Consulting Services, Inc. ("ICS") and all foreign subsidiaries other than Blue Cross of Jamaica. GHMSI has terminated its contract with B'nai B'rith, which was originated and administered by Protocol, but B'nai B'rith has challenged GHMSI's right to terminate the contract at this

---

[9] Four days following his retirement, Mr Gamble wrote to Mr. Giuliani, with copies to the Board, criticizing Mr. Giuliani for suggesting that the diversification strategy had to be abandoned in the wake of no longer endurable losses. Mr. Gamble asserted his "opinion that diversification has presented GHMSI with the opportunity to become a highly successful organization in the future." Mr. Gamble continued by characterizing the subsidiary losses as "short-term results"—a theme to which he always has been devoted. Moreover, despite the compelling business and financial issues thrust upon GHMSI as the result of the execution of his diversification strategy, Mr. Gamble wrote that

"If one were to study the trends of revenue and gains or losses, as well as learning of the multitude of building relationships which would continue the positive trends toward substantial improvement in our financial results, *one would not label the diversification strategy as a failure, but rather as a significant accomplishment and a notable success.* (Emphasis added).

[10] Appendix C identifies the current Board members and provides some information about their background.

time. GHMSI intends to continue to perform its obligations on a voluntary basis through March 31, 1993, so that B'nai B'rith subscribers should be protected until the dispute can be resolved by arbitration or mutual agreement. GHMSI, S.A. and 13 of the 14 subsidiaries of the Assistance Division have been sold. A sale of Blue Cross of Jamaica is being actively pursued. Up to 10 additional subsidiaries, including Protocol, will be sold or closed in 1993.

Henceforth, GHMSI's subsidiaries will be limited to those which directly complement the core business. Even within this group of related subsidiaries, there will be an ongoing review to ensure that each and every entity is critical to the financial success of the core business. The contributions of CapitalCare and the life insurance subsidiaries are readily apparent. Other subsidiaries, such as National Capital Administrative Services, Inc. ("NCAS") and Health Management Strategies International, Inc. ("HMS"), are more problematic. NCAS has not been profitable, but was reasonably intended to maintain relationships with subscribers who wished to move to a third-party administrator system. NCAS has consistently lost money, but major changes have been made that are expected to make it profitable. HMS, by contrast, has become consistently profitable over the past few years. Yet its future growth probably will require a significant capital investment and its services may not be critical to the mission of the core business in becoming a managed care company, thus arguing for a sale of the business. GHMSI is presently considering an outside offer to purchase HMS. These examples illustrate that decisions about the future of subsidiary operations, even subsidiaries closely linked to the core business, raise complex questions and require careful consideration of competing factors. Often, the proper decision is not obvious. What is not debatable is that GHMSI has absolutely committed itself to scrutinizing these operations and making the necessary decisions.

Unfortunately, the decision to close or sell businesses does not immediately eliminate adverse financial consequences from the problem subsidiaries. GHMSI expects to suffer an overall loss in 1992 of up to $38.8 million, which will, of course, reduce reserves. Protocol, World Access, NCRe, and the International Division collectively lost some approximately $25.6 million from operations in 1992. Furthermore, the decision to close businesses, including the termination of the Protocol administered B'nai B'rith program, has resulted in the requirement, under GAAP, that all future contingent losses under that contract be recognized in GHMSI's 1992 financial statements. GHMSI is also being required to make certain accounting charges and write-offs to comply with regulatory requirements.[11]

Beyond the decrease in reserves attributable to 1992 operating results, the Virginia Bureau of Insurance has also required certain adjustments that have significantly reduced GHMSI's reserves as calculated on a statutory basis. Based on a revised appraisal in early 1992, the value of GHMSI's headquarters building was decreased by $22 million. GHMSI has been required to discount entirely its investment in Blue Cross of Jamaica and to recognize accrued vacation pay. It also anticipates that it will be required to recognize certain of the future losses attributable to the B'nai B'rith contract. The combined impact of the 1992 operating results and the other required adjustments has been to decrease GHMSI's reserves, as calculated on a statutory basis, from $101,962,000 at December 31, 1991 to approximately $48.4 million at December 31, 1992.

GHMSI had over a billion dollars in revenues in 1992 and currently has more than $90 million in investment assets, more than $300 million on its balance sheet set aside for unpaid claims, as well as other assets that are either ignored or discounted by accounting principles. It has ample cash flow. Although GHMSI still has millions of dollars of statutory reserves, the Virginia Bureau has taken the position that GHMSI's reserves do not satisfy its statutory requirements, Under Virginia law, the Bureau can require reserve levels in an amount "up to" 45 days of anticipated operating expenses and incurred claims expense generated from subscription contracts issued by GHMSI. Although that provision would seem to be discretionary, the Virginia Bureau has taken the position that GHMSI must meet the maximum of 45 days. As applied to GHMSI, the Virginia Bureau's 45 day requirement man-

[11] Overall, operating losses and future contingencies associated with subsidiaries that are being closed produced losses of approximately $47.1 million. GHMSI's gains from the operations of those businesses that are being retained primarily the core business—and the realization of additional gains from its sales of securities offset some of those losses, resulting in an overall estimated loss for 1992, on a GAAP basis, of approximately $38.8 million.

dates reserves in the amount of approximately $46 million as of December 31, 1992.[12]

Moreover, the Virginia Bureau has insisted that Virginia subscribers be covered by reinsurance to be purchased at substantial cost by GHMSI. To address the Virginia Bureau's concerns about protecting the interests of Virginia subscribers, BCBSNCA has agreed to obtain reinsurance, at an estimated cost in 1993 of $2,800,000, for its Virginia "at risk" accounts. Despite the reinsurance, the Virginia Bureau has not exercised its discretion to reduce its 45-day reserve requirement in recognition of the substantial additional protection for Virginia subscribers provided by the reinsurance. This double-barreled approach by Virginia has caused GHMSI to seek other sources for additional reserves.

In an effort to satisfy Virginia's requirements, GHMSI arranged with the Association for the infusion of $15 million in the form of a Surplus Note. That infusion, while helpful, is not a permanent solution because the terms of the Surplus Note require GHMSI to repay it by February 18, 1993. Rather than invite unnecessary confrontation at this time, GHMSI has continued to pursue alternatives for increasing reserves. One option under active consideration is the sale of HMS, a profitable subsidiary. Another option, and the one that the Board has pursued most vigorously, is an affiliation with Blue Cross Blue Shield of Virginia.

GHMSI has not relied solely on the assistance of outside parties in addressing financial issues. As the Committee is aware, GHMSI has developed a detailed business plan to guide its divestiture of unprofitable subsidiaries and its effort to rebuild reserves beginning in 1993. That business plan recognizes the need for sacrifice. Four hundred positions are being eliminated, including almost 25 percent of management staff. All salaries are being frozen. Employee benefits are being reduced in a number of respects. There is an ongoing effort to identify further ways in which GHMSI's costs can be reduced. The business plan reflects conservative assumptions and a pragmatic outlook for the future. It demonstrates that a GHMSI dedicated to the core business can return to solid profitability in 1993.

GHMSI's ability to achieve its business plan obviously depends upon a number of factors—some of which are within its control and some of which decidedly are not. For its part, GHMSI must be vigilant in its dedication to restraining administrative costs and must maintain its historical commitment to customer service. Given the radical changes that have occurred within the organization in a short period of time, GHMSI believes that it has credibly demonstrated its commitment to this approach. GHMSI recognizes, however, that the true test will be how well it meets subscriber needs in the months and years ahead.

The attitude and actions of GHMSI's regulators are equally critical. Notably, the Insurance Department for the District of Columbia, which is GHMSI's primary regulator by reason of recent Congressional action, while vigilant and legitimately interested in GHMSI's restructuring effort, has attempted to play a constructive role throughout the process. That office has been reviewing GHMSI's business plan and appears to share GHMSI's belief that it should be given a meaningful opportunity to begin rebuilding reserves and to pursue the affiliation negotiations which are today at a sensitive and important stage. The District has demonstrated a willingness to work with GHMSI to develop a constructive approach that will protect the interests of all subscribers. Its regional approach is both responsible and realistic given the community in which we live. GHMSI hopes that the hearing process will assist in identifying points of consensus among the regulators and that the District, Virginia, and Maryland will work together in forging a common, and constructive, approach.

Finally, and perhaps most importantly, it is vital that in order for GHMSI to succeed in its current efforts the continual public battering of GHMSI must come to an end. GHMSI does not blame the messenger of bad news for its problems, but given its demonstrable commitment to addressing the problems of the past aggressively, it

---

[12] Maryland and the District of Columbia have much different reserve requirements. In Maryland, while the situation is unclear, it appears that there must be $75,000 in unencumbered assets net of liabilities at all times. District laws do not explicitly impose a minimum reserve requirement for health insurers, but the Insurance Commissioner presently has set the minimum for GHMSI at $1.5 million, equal to the minimum for life insurers operating in the district. While the Maryland and D.C. levels are arguably inadequate and legislation is anticipated which would raise those levels, Virginia's requirements, as interpreted by the Bureau, some might consider to be excessively strict and inflexible. Virginia's 45 day rule does not apply to the Virginia Plan because it is a mutual company. The conflicting reserve requirements of the three jurisdictions underscore the difficulties that confront GHMSI in attempting to comply with the requirements of three different regulators.

is now obvious that the time has come to move beyond the effort to assign blame and to focus upon the very real interests served by GHMSI in this community.

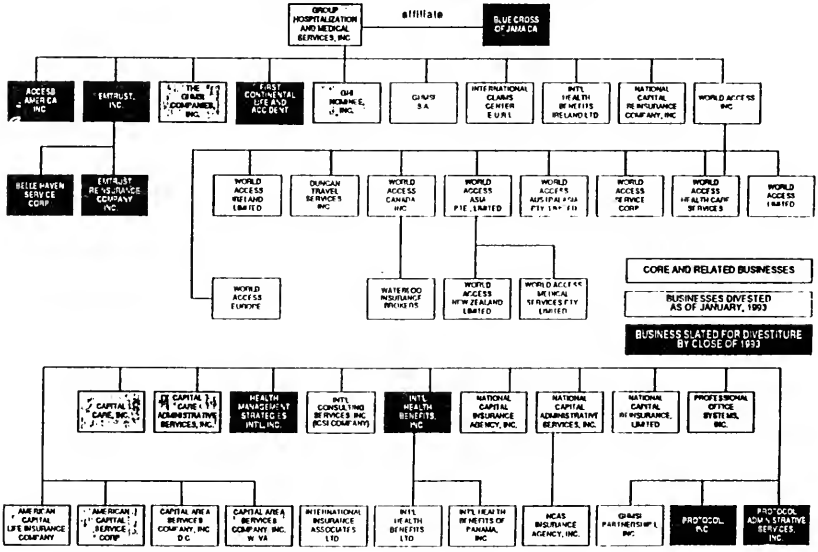
If, as GHMSI anticipates, an affiliation with the Virginia Plan which fully and responsibly addresses the interests of all subscribers can be consummated, metropolitan D.C. will be well served and all who assisted in the process, including this Subcommittee, the regulators, GHMSI, and the Virginia Plan, can point to a significant accomplishment. Moreover, the affiliation concept points a clear direction for the future of non-profit health plans. Regionalization of Blue Cross/Blue Shield Plans in this area has been discussed for years. The advantages of regionalization are obvious—increased cooperation between different Blues Plans and improved service for subscribers with operations in different jurisdictions. The Association has cited the affiliation effort "as an example of how two Plans in adjacent areas can join forces to share capabilities to better serve customers." An affiliation between the Virginia Plan and GHMSI would allow more effective competition with commercial insurers in the attractive Northern Virginia market. Moreover, the coming competitive struggle over managed care will require resources that the Blues Plans probably can achieve only through combinations such as this one. An affiliation would also produce obvious cost efficiencies which will make the combined entity a prominent participant in the health insurance business in this region.

VI. Conclusion

GHMSI retains significant strengths and assets. It has a dedicated work force that understands subscriber needs. It has developed systems that provide efficient and effective claims processing. It has developed a pioneering approach to the delivery of managed care in a cost effective way. It has cultivated strong relationships with its provider hospitals. It has served the needs of individuals and small business who want health insurance. No for-profit insurance company would ever volunteer to become an insurer of last resort, particularly for a large urban center. Having confronted the problems of the past, GHMSI stands ready to move forward. Indeed, the effort to pursue a combination with the Virginia Plan demonstrates GHMSI's clear understanding of its obligations and its willingness to take bold and innovative action to promote the interests of subscribers.

APPENDIX A

GHMSI'S Organizational Restructuring



APPENDIX B

I. The Subsidiaries

A. Health Management Strategies International, Inc.

The performance of Health Management Strategies International, Inc. ("HMS") illustrates the benefits that diversification can provide. Created in 1985, HMS has provided cost-containment services for more than 10 million members on behalf of 300 clients. HMS manages utilization of health services through a highly effective utilization review program. Under the program, HMS reviews the appropriateness of hospital care before a patient is admitted to a hospital and throughout the hospital stay.

In 1988, HMS developed and provided mental health utilization review criteria and training to a number of other Blue Cross and Blue Shield Plans and insurance companies. The managed mental health care network established by HMS in 1991 covers more than 100,000 persons in the Washington, D.C. area.

The success of HMS's utilization management services was solidified in 1989 when it received a five-year multi-million dollar contract to provide mental health care utilization management services for 6.5 million beneficiaries of the Civilian Health and Medical Program of the Uniformed Services ("CHAMPUS') contract. CHAMPUS is the civilian component of the military and veterans health care systems.

HMS's performance under the CHAMPUS contract, the largest contract of its type ever awarded by the federal government, has been enormously successful. The contract therefore has been amended several times to provide for expanded services by HMS. For example, HMS now audits CHAMPUS treatment facilities to ensure that they are being operated efficiently. When signed in 1989, the contracts value to HMS over a five-year term was $65 million; as a result of the modifications, its current value is $80–$90 million. HMS plans to bid on a renewal when the present contract expires in 1994.

The Alexandria, Virginia-based company has also profited from such products as performance analysis (an evaluation of the appropriateness of care after it has been received), prenatal review (early identification and management of high-risk pregnancies), and surgical procedure review (reviewing the medical necessity for surgical and diagnostic services).

HMS became profitable in 1990, earning approximately $900,000 that year and $1.3 million in 1991. Current projections forecast a profit of $2.7 million on revenues of approximately $29.2 million for 1992 and $2.1 million on revenues of approximately $29.6 million for 1993.[1]

B. CapitalCare. Inc.

CapitalCare, Inc., GHMSI's health maintenance organization ("HMO"), exemplifies GHMSI's potential in developing full managed care capabilities. Operating in the Washington, D.C. metropolitan area, CapitalCare serves its own subscribers and those of BCBSNCA as part of the new Capital Choice product.

Capital Choice is a point-of-service product which offers varying levels of benefits including managed care and traditional indemnity insurance. Since the introduction of Capital Choice in 1991, membership for that product has grown from 13,000 in July 1990 to over 90,000 at year end 1992. Capital Choice is the first major step in the coupling of BCBSNCA and CapitalCare to create a comprehensive managed care environment. The physical combination of the two entities is expected to be completed in 1994.

CapitalCare is well positioned to serve both of these growing markets, and the company has now firmly established its position as one of the top five managed care companies in the D.C. metropolitan area. CapitalCare Administrative Services, Inc., a subsidiary of GHMSI, offers a Dual Option Program that provides subscribers with a choice between traditional Blue Cross and Blue Shield coverage and HMO-type benefits for the same price.

In addition, through its participation in HMO-USA, a nationwide network of HMOs affiliated with Blue Cross and Blue Shield Plans, CapitalCare has served as the control plan for seven national employers and has provided care for employees of another 12 such national accounts. Through HMO-USA, employers can provide

---

[1] Early in 1992, it became clear that GHMSI could sell HMS's and recognize a fair gain on its investment, while still benefiting from HMS' service. Therefore, an investment banking firm was engaged to assist GHMSI, and GHMSI is currently in the final stages of confidential negotiations to sell HMS.

HMO coverage to employees across the nation, yet receive just one bill from a designated "control" Blue Cross and Blue Shield Plan.

As CapitalCare has grown from startup in 1984 to a sustainable entity, its financial performance has greatly improved. One reason for Capital Caress early losses can be attributed to the management in place at the HMO at that time. Since undergoing a change in management, as well as the institution of appropriate managed care techniques, performance has improved dramatically. Some of the net losses CapitalCare experienced from 1984 to 1989 can be attributed, in part, to the fact that it wad financed with debt. For example, in 1989 CapitalCare's net loss of $912,000 included an interest expense of $2.5 million; if it had been capitalized with equity, it would have generated pre-tax net income of more than $1.5 million.

Even with its debt service obligations, CapitalCare has been profitable since 1990. Its below-forecast performance in 1991 can be attributed to a dispute arising from an audit of CapitalCare by the Office of Personnel Management ("OPM"). From 1986 to 1991, CapitalCare offered coverage to federal employees under the Federal Employees Health Benefit Program ("FEHBP") sponsored by OPM. As a result of a routine audit the Inspector General's Office conducted on behalf of OPM, there was a disagreement over the rates charged to OPM for the contract years 1988, 1989, and 1990. The Inspector General's Office maintained that CapitalCare had overcharged OPM in excess of $6 million based on the fact that CapitalCare's rates for OPM were higher than non-federal groups with similar benefits.

CapitalCare's contract with OPM was community rated, which is analogous to a fixed price contract. No retrospective adjustments were made based on experience. OPM sought a downward adjustment in the rating to the lowest amount charged any customer. CapitalCare, unlike most HMOs, has the capability of experience rating, adjusting its rates based on retrospective analysis. Therefore, CapitalCare experience rated the OPM contract and determined that it had suffered a loss of $2.9 million in 1988 and a gain of $1.9 million in 1989. CapitalCare maintained that if the problem was defective pricing, 1988 and 1989 should be viewed together, which would have resulted in OPM owing money to CapitalCare. OPM, instead, ignored the loss in 1988 entirely and insisted on an adjustment to eliminate the 1989 gain.

To resolve the dispute, CapitalCare negotiated a settlement with OPM requiring a payment of $1.9 million, the profit earned in 1989. Since OPM had been retaining premiums totalling $1.2 million, CapitalCare paid an additional $700,000.

CapitalCare's membership nearly doubled in 1992 from 63,000 to over 115,000 by year end. At the same time, profitability is expected to exceed $4.5 million in 1992. The company expects to increase its competitiveness and continue its growth in 1993 with changes to its medical underwriting policies, benefit structure, rating policies, and market segments. Total membership is forecast to climb to 190,000 and profitability in 1993 is forecast at $900,000 on revenues of over $46 million.

C. American Capital Life Insurance Co.

In an effort to integrate into the enterprise underwriting group life and disability insurance, GHMSI purchased American Capital Life Insurance Company ("AmCap") in 1988. AmCap currently underwrites group life and disability insurance in D.C., Maryland, and Virginia. AmCap's administrative functions are performed primarily by National Capital Insurance Agency, Inc. ("NCIA").[2] BCBSNCA sales representatives perform AmCap's marketing. AmCap targets BCBSNCA's small (under 100 employees) group of customers.

AmCap has consistently earned modest profits since 1989. For example, AmCap is expected to earn approximately $200,000 on net premiums (total less ceded premiums) of $3.7 million in 1992. For 1993, AmCap is forecast to earn $400,000 on flat net premium revenues of $3.8 million. AmCap fills an important corporate purpose by providing GHMSI with the means for offering insurance products that complement the basic health insurance offerings.

D. Professional Office Systems Inc.

Organized in June 1985, Professional Office Systems, Inc. ("POSI") offers data processing services, computer hardware and software and office systems advice to physicians, dentists, and hospitals. The purpose of POSI is to promote the automation of claims filing in a manner that will complement BCBSNCA's data processing system. Although POSI has typically lost small amounts of money, its true benefit to the organization comes from the promotion of electronic claims filing, a practice that significantly reduces errors and improves the overall efficiency of the process.

---

[2] NCIA was founded in 1978 to retain control of BCBSNCA group health accounts by offering third-party group life insurance products.

The efforts of POSI have reduced BCBSNCA's administrative costs annually by amounts significantly greater than POSI losses and improved customer service.

Because BSBCNCA continues to modify its data processing systems, particularly with the advent of managed care, POSI will continue to play an important role in the core business. Current plans call for the continued operation of POSI.

E. Blue Cross of Jamaica

For the past 37 years, Blue Cross of Jamaica ("BCJ") has served as Jamaica's largest health insurer, providing service to over 300,000 Jamaican subscribers and beneficiaries. BCJ has 60 percent of the private Jamaican health care market. Fifty percent of BCJ's business is in an administrative-services-only contract with the government (teachers, civil service, and police) and the other half is commercial.

In 1987, Hylton McIntosh, the Executive Director of BCJ, contacted Mr. Gamble to discuss the possibility of an affiliation between BCJ and GHMSI. Mr. McIntosh explained that BCJ had encountered financial difficulties arising out of the renovation of its Kingston headquarters and the development of adjacent condominiums. BCJ built the condominiums at the insistence of Kingston zoning authorities who had conditioned the issuance of a permit for the headquarters' renovation on their development. Cost overruns and exorbitant interest rates subsequently saddled BCJ with enormous debt. The sale of a number of the condominiums did not fully alleviate the severe cash shortage.

By affiliation, GHMSI hoped to provide BCJ with essential marketing, training, and support services while solidifying its own foothold in the Caribbean. At that time, GHMSI administered the health benefits program for the government of the Virgin Islands and offered programs to the private sector of the Virgin Islands; the annualized revenue of the latter was nearly $3.5 million.

In July 1987, Mr. Gamble presented a four-part proposal to the Board. First, GHMSI would pay $5 million to BCJ to liquidate BCJ's debts and replenish its cash accounts. Second, BCJ would agree to merge into GHMSI. Third, by agreement, BCJ would operate as a division of GHMSI. And fourth, GHMSI would appoint to its Board a BCJ representative and BCJ would appoint at least two GHMSI representatives to its Board.

Pursuant to an agreement dated July 24, 1987, GHMSI received eight of the twelve seats on BCJ's Board of Trustees. GHMSI, in turn, provided BCJ with a cash infusion of $5 million. BCJ used part of this sum to retire BCJ's mortgage loan with National Commercial Bank and the note payable to the Bank of Nova Scotia.

In November 1990, BCJ's new President and CEO, Dr. Henry W. Lowe, requested an additional $1.5 million, primarily to liquidate GHMSI's accounts receivable from BCJ and to provide additional working capital.

BCJ operations have steadily improved under Dr. Lowe's leadership. BCJ conservatively anticipates a net gain of $35,500 from operations in 1992 due to staff reductions and efforts to lower administrative expenses by 15 percent.[3] The company also is attempting to reduce its claims processing expenses by moving computer operations in-house in 1993 to relieve the expense of its current data ;processing contract with a computer vendor controlled by a competitor.

Revenue is expected to increase by 40 percent in 1993 due to increases in rates and business retention. BCJ is forecast to lose $74,300 on net revenues of $9.7 million due in part to a write-off of computer software.

While no timetable exists for repayment of GHMSI's $6.5 million investment, the value of BCJ's Kingston headquarters and condominiums has appreciated substantially. Efforts are underway to establish a repayment schedule for the $6.5 million through the issuance of a formal surplus note. Also, GHMSI is pursuing avenues to divest BCJ and hopes to consummate a transaction in 1993.

F. EmTrust. Inc.

EmTrust, Inc. was formed in 1987 as a joint venture with Inova Health Systems, Northern Virginia's largest medical provider, to offer benefits management for self-funded and directed employee benefits plans. GHMSI and Health Enterprises, Inc., a wholly-owned subsidiary of Inova which acts as a holding company, each hold a 50 percent interest in EmTrust. Developed conceptually by Mr. Giuliani and John O'Brien of Inova, EmTrust was established to offer self-insured employers a package of health insurance-related services that would provide the administrative convenience of full insurance at a reduced cost.

---

[3] This amount does not reflect a negative adjustment of approximately $105,000 of 1991 BCJ audit adjustments that are included in GHMSI's 1992 consolidated results for BCJ. Those audit adjustments occurred during the 1991 year-end audit of BCJ.

Through approximately five years of operation, EmTrust and its subsidiaries have sustained losses in excess of $6 million. A substantial portion of the losses is attributable to decisions by its former president to offer the EmTrust product, including the excess insurance component, at prices lower than those required by actuarial analyses. Price-cutting may be appropriate in isolated instances, but EmTrust renewed certain accounts without raising premiums, even after adverse claims experience had revealed the errors in the initial price setting. EmTrust was plagued by an excessive focus on sales and renewals. Substantial losses began to appear during the Spring of 1991 and when those losses persisted despite changes in some business practices, Emtrust's president was removed in early 1992. Renewed emphasis was placed on controlling costs and eliminating unprofitable accounts.

GHMSI and Inova are currently negotiating the final terms of Inova's assumption of GHMSI's interest in EmTrust.

G. World Access. Inc. and Access America. Inc.

World Access, Inc. was formed in 1982 by Dr. Sol Edelstein, an emergency medical systems specialist at George Washington University hospital, to offer international medical assistance to Americans travelling abroad. Dr. Edelstein's concept of providing travellers with a worldwide network of medical providers and a multi lingual hotline was based on the model of European assistance companies. Recognizing the need to offer an insurance component with the product, Dr. Edelstein met with Mr. Gamble, initially to discuss GHMSI's provision of insurance coverage for World Access customers. Instead, Mr. Gamble proposed that GHMSI invest directly in the enterprise. Under the business plan, Dr. Edelstein would use his expertise to establish the delivery systems and provider network and GHMSI would market the World Access product as a value-added service both to its own subscribers and to other Blue Cross Blue Shield Plans. GHMSI provided $500,000 for the initial capitalization of World Access and received a 51 percent interest in the company.

No systematic market research appears to have been conducted prior to GHMSI's investment in World Access. Although Dr. Edelstein succeeded in establishing a comprehensive international infrastructure for World Access as well as a fully-staffed, 24-hour multilingual "hotline," the anticipated client base did not materialize. Whether or not World Access as originally conceived could have been successful is unclear because the fate of the enterprise was dictated by GHMSI's decision in 1985 to pursue what ultimately proved to be a costly joint venture with Empire Blue Cross and Blue Shield (a Plan with its headquarters in New York City).

Through Access America, Empire planned to sell travel products, including assistance services, to Plan subscribers. Under the joint-venture arrangement, Access America would market the travel products and administer claims, while World Access would us& its 24-hour operations center to service customers as claims arose. From GHMSI's perspective, investment in Access America was primarily a defensive move to protect World Access through an exclusive contract to provide all assistance services for Access America. Empire received a 60 percent interest in Access America; GHMSI owned the other 40 percent. Although GHMSI received minority seats on the board, Empire controlled all operating decisions at Access America. BCS, an entity owned by certain Blue Cross and Blue Shield Plans, became the underwriter for the various lines of travel insurance sold through Access America, including lost luggage, evacuation, and trip-cancellation insurance.

Access America expanded its business rapidly by focusing on travel agents and tour operators. It also contracted with some of the major credit card companies to provide travel products to their cardholders. Unfortunately, underwriting errors, attributable to both BCS and Access America, had adverse consequences, for which GHMSI ultimately paid. It was discovered in 1987 that BCS's trip-cancellation policies could be construed as covering losses from the insolvency of a tour operator. Under one such policy, Access America became exposed in 1987 to a potential $8 million claim from American Leadership Study Groups, Inc. ("ALSG"), a student tour operator, which claimed a shortfall of at least $2 million for upcoming student trips.

In an atmosphere of urgency, and apparently without any meaningful due diligence, Access America advanced ALSG $2.5 million in cash, guarantees, and letters of credit to cover upcoming trip expenses. Minimal investigation would have revealed that ALSG had lost money the preceding two years and that it had no audited financial statements; more thorough investigation would have uncovered the true cause of ALSG's threatened insolvency—its President, Gilbert Markle, had used deposit monies to cover other business and personal expenses.

In each of the three subsequent years, at ALSG's request, Access America advanced monies to ALSG to cover purported shortfalls in operating funds. As a

result, by late 1990, Access America held approximately $11.1 million in receivables from ALSG.

Also in 1990, BCS was becoming increasingly discontent with its risk exposure from Access America's business. The conflict between BCS and Access America intensified and in late summer 1990 BCS threatened to send cancellation letters to the credit card companies with whom Access America had contracts. The issuance of cancellation letters would have had ruinous consequences for World Access, whose business by that time was essentially a captive of Access America.

In response, GHMSI decided to acquire Empire's interest in Access America, a decision that proved to have significant financial repercussions. By the time the transaction was presented to GHMSI's Board a crisis had erupted, with the acquisition being portrayed as the only way to avert the destruction of World Access. No opportunity existed for deliberation on the business wisdom of the deal. No independent due diligence had taken place; as it turned out, Access America did not even have audited financial statements for 1989.

As structured, the deal was unfavorable to GHMSI. GHMSI assumed Empire's share of Access America's ongoing liabilities and agreed to repay a portion of Empire's investment. GHMSI also entered into a disastrous side deal with BCS, capping at 90 percent BCS's loss ratio for claims after August 3, 1990 (the date the acquisition closed). BCS later claimed that the cap applied to all claims incurred—not just business written—after that date, a position that caused Access America to write off $3.2 million in December 1991.

Once GHMSI took over Access America and installed Dr. Edelstein as CEO, the true dimensions of the company's problems became apparent. Claims processing was woefully backlogged, accounting systems were inadequate, no integrated computer system existed, and numerous contracts had to be revised or cancelled, creating liabilities for the company. Access America's operations were transferred from New York to Richmond in late 1990. That move was critical for consolidating operations and lowering costs, but it involved an immediate cost in excess of $3 million.

Along with the other quagmires left by Access America's prior management and BCS, and deepened by Empire's abandonment, Dr. Edelstein also had to resolve the ALSG dispute. After Markle failed to meet the terms of a negotiated workout, Access America obtained control of ALSG and ownership of real estate. The plan was that Access America would operate ALSG in order to put it in shape for a sale, thus recouping some of the loss. Unfortunately, in the spring of 1991, Mr. Gamble decided to sell ALSG and the real property to Sam Cooper, a putative representative of La Jolla University, for $3.4 million. Cooper, who had put no money down, failed to make any of the quarterly interest payments due on the promissory note and by the time of default, approximately $1,000,000 had been withdrawn from the student accounts. It was later discovered that Cooper had no legal connection with La Jolla. GHMSI suffered additional losses when it advanced funds to ensure that students travelling on ALSG tours during the summer of 1991 were not stranded overseas, and ALSG was placed in receivership in July 1991.

GHMSI has redeemed its shares in World Access as part of GHMSI's ongoing restructuring. Although that transaction could not erase any of the historical deficits, GHMSI will avoid incurring additional operating losses or the substantial costs associated with closing the business. GHMSI also received cash consideration of $1 million from World Access for the sale of the World Access subsidiary in Canada, and from the management of World Access Australasia in its buyout of that subsidiary. GHMSI also expects to receive future earn out and profit sharing payments which have not been accrued.

H. International Division

GHMSI's venture into the international market grew out of the Company's diversification strategy and the belief that expansion in that direction would be a natural outgrowth of GHMSI's location in Washington, D.C. and its activities, such as World Access, which were designed to reach Washington's large international community. Unfortunately, as was generally true of GHMSI's diversification strategy, there was no coherent business plan concerning expansion into the international market. Specifically, there appears to have been little consideration given to whether GHMSI's experience as a domestic insurer was translatable to the international market, or whether its experience as a direct insurer provided the requisite skills for success in the reinsurance business.

GHMSI's international activities initially were conducted through subsidiaries operating directly under GHMSI. By October 1988, the number of domestic and foreign subsidiaries had so grown that Mr. Gamble recommended switching to an organizational structure in which the International Division would operate as one of sev-

eral coequal branches within GHMSI. The International Division's business eventually encompassed five market Segments—Latin America, the Caribbean, Europe, Asia, and Specialized—with offices in Washington, D.C., Singapore, Mexico City, St. Thomas, Dublin, and Paris.

GHMSI's first effort abroad occurred in 1984, when it was awarded a contract to provide direct health insurance coverage to United States Virgin Islands ("USVI") government employees and their families. Significant and continuing problems rendered the contract unprofitable. GHMSI received little cooperation from the USVI government, which often was late with payments. In addition, GHMSI's rates were consistently inadequate and when a 30 percent rate increase was implemented in 1989 the USVI government cancel led the contract.

GHMSI's USVI contract led to the creation of International Health Benefits, Inc. ("IHB, Inc."), which was formed in 1985 to perform administrative functions for the USVI account. By 1990 it had become the administrative center for virtually all direct insurance and reinsurance business underwritten by the International Division on behalf of GHMSI.

GHMSI's foray into the USVI also led to unprofitable ventures throughout the Caribbean in places such as Jamaica and Barbados. As with the USVI contract, most of this business involved direct insurance, whereby GHMSI would provide health insurance to citizens in their home country. These business ventures lost money because of inaccurate actuarial analysis and the high utilization of the full-scale benefits GHMSI offered in a market unaccustomed to such coverage.

Another aspect of GHMSI's international business was the provision of "out-of-country" coverage to insureds living outside of the United States. For example, GHMSI entered into contracts with a major Mexican insurer whereby GHMSI provided nationwide[4] emergency medical treatment to Mexican subscribers who became ill while in the United States. The contracts were profitable, because they provided only for emergency treatment and were administered at low cost from GHMSI's Washington, D.C. office. GHMSI entered into similar contracts with other insurers in Lain America with generally good results.[5]

GHMSI tried to replicate its Mexican success in Europe. In 1988, GHMSI had established the subsidiary of International Health Benefits, S.A. ("IHB, S.A.") in Paris to serve as the French arm of IHB, Inc. In 1990, this entity was renamed GHMSI, S.A. It offered coverage to Europeans traveling outside their home country, and then ceded all risk to another GHMSI subsidiary. It aggressively pursued business in Poland, Czechoslovakia, and the former Soviet Union, without a comprehensive study of the risks involved in business ventures in those fledging economies. The European subsidiary was consistently unprofitable, as it never attracted enough subscribers to outweigh the extremely high administrative costs, and it suffered major setbacks after GHMSI lost the trademark suit concerning use of the BCBS name. As discussed later, this subsidiary was sold in December 1992.

International Health Benefits (Ireland), Ltd. ("IHB Ireland") was established in 1989 to act as a reinsurer for the other subsidiaries of the International Division. It was set up within a trade enclave in Dublin in order to take advantage of a 10 percent corporate tax rate, although the expected tax benefits have not been realized. In exchange for a premium,[6] IHB Ireland reinsured approximately 80 percent of the international risk assumed by the subsidiaries, generally in connection with the offer of out-of-country benefits to the subscribers of foreign insurance companies. The remaining 20 percent of the risk was ceded to Lloyd's of London.

IHB Ireland's relationship with Lloyd's of London led to the creation of two additional subsidiaries on the Isle of Guernsey in 1989. Each of IHB Ireland's contracts with Lloyd's had to be placed by a broker, who earned a commission. IHB Ireland developed a close relationship with a broker with the firm of Wackerbarth Hard-

---

[4] GHMSI arranged for nationwide coverage through the cooperation of other BCBS Plans.

[5] International Health Benefits of Panama, Inc. ("IHB Panama") was created in 1988 in connection with a joint venture with a Panamanian insurer, whereby GHMSI would reinsure 90 percent of both in-country and out-of-country risk. IHB Panama was established as a Panamanian corporation to be used in the event that the Panamanian partner required technical services. Those needs never arose, so IHB Panama remained a shell corporation; it never conducted any business. The Panamanian contract was unusual both because of the amount of risk GHMSI retained and because it involved reinsuring in-country risk. It was also the only one of GHMSI's Latin American reinsurance ventures to prove unprofitable. IHB Panama has now been officially dissolved.

[6] As with other GHMSI subsidiaries, premiums were set based upon actuarial data provided by International Consulting Services, Inc. ("ICS"), a GHMSI subsidiary established to provide actuarial services. ICS discontinued operations in December 1992. IHB Ireland eventually retained its own actuaries to review ICS's work.

man Ltd. ("WHL"), who in 1989 proposed sharing the commissions with the result that IHB Ireland would receive a 50 percent discount on its commission payments. To this end, International Insurance Associates Limited ("IIA") was created in Guernsey to function as a shell corporation, with ownership split between WHL and GHMSI. WHL assigned to IIA all of the commissions from the transactions with IHB Ireland; at the end of the year, the commissions were divided. GHMSI's share then was transferred to International Health Benefits, Ltd. (Guernsey) ("IHB Guernsey"), another shell subsidiary established specifically for this purpose, for forwarding back to IHB Ireland. This arrangement, although complicated, did produce a net contribution to GHMSI revenues. These two subsidiaries are in the process of being dissolved.

The International Division consistently failed to meet financial projections. Losses were incurred in both 1990 and 1991. Each market segment incurred losses during those years, except for the Specialized Market, which showed a profit in 1990, and the Latin American market, which was profitable both years. This trend continued in 1992, when the Division suffered overall losses of approximately $6.7 million, which included the costs of disposing of a number of the subsidiaries. For 1992, the Latin American market is projected to have a profit of $1.0 million; in contrast, the Caribbean market projects a $3.3 million loss.[7]

As a result of GHMSI's renewed focus on its core business, most International Division subsidiaries have been or will be closed. The Company will retain only those portions of the business which are profitable and those which cannot be transferred or cancelled, such as a contract covering Malaysian students, which is due to expire in 1994. Thus, efforts are underway to shut down operations in Singapore and the Caribbean and are in the process of dissolving the legal entities in Ireland and Guernsey. The following actions have been taken:

—Ninety-five percent of the interest in GHMSI, S.A. has been sold at a modest profit to a French company. While the terms of the sale require GHMSI to retain a 5 percent interest for two years, GHMSI no longer holds any risk insured by the former subsidiary.
—IHB Panama has been dissolved; the dissolution of IHB Guernsey, IHB Ireland, and IIA is under way.
—Many of the Caribbean contracts will be assumed by Alden Risk Management Services, effective February 1, 1993, and GHMSI is in the process of cancelling other contracts.
—The St. Thomas office is scheduled to be closed effective March 31, 1993; and the Singapore office will be closed effective April 1993.

At present, GHMSI plans to continue operating its profitable Latin American business. Revenues from this market are expected to exceed $15 million during 1993, with all but $1 million forecast to come from growth in existing markets. The Specialized market, which includes Overseas Schools and Religious and Relief Workers, will be retained but will not be expanded. The surviving portions of the International Division are expected to earn a profit in 1993 of $1.2 million, which is consistent with the past profitability of these markets. Nevertheless, because of the lack of strategic fit between the entire International Division and the core business, Division executives have been given permission to pursue a sale of even these profitable enterprises.

I. National Capital Administrative Services. Inc.

National Capital Administrative Services, Inc. ("NCAS"), headquartered in Fairfax, Virginia, was incorporated in 1983 and became operational in 1984. NCAS was established to serve as a third-party administrator ("TPA"), providing claims processing capability to self-insured health care plans. TPAs were becoming a significant market force, and it was hoped that NCAS would enable GHMSI to retain existing accounts that were changing from traditional health care plans to TPAs, enroll groups in the process of switching to a TPA, and attract groups seeking to change from one TPA to another.

Because it needed access to a sophisticated computer system to service accounts, NCAS entered into contracts with Insurdata, Inc., a Dallas computer company that provided claims processing capability. NCAS first acquired the exclusive rights to use the Insurdata system within the mid-Atlantic region. It later acquired national rights to the system, 18 percent of the stock of Insurdata, and one of three seats on

[7] Cost reduction measures implemented in late 1992 saved approximately $0.5 million, however. These measures included cuts in salaries and other employee benefits, resulting in a 20 percent savings in administrative costs for the fourth quarter of 1992.

the Insurdata board. While the initial decision in the mid-1980s to use the Insurdata system may have been reasonable, the decision to expand the use of Insurdata and invest directly in it was made in an atmosphere of urgency when NCAS learned that Insurdata was eagerly seeking new capital.

NCAS's business has had several areas of focus. First, NCAS has licensed the use of the Insurdata computer system to other BCBS Plans which operate their own TPAs. By 1992, 12 Plans, representing over 80,000 insureds, were using NCAS's services. Second, NCAS acts as a TPA for a number of self-insured plans representing more than 37,000 insureds. Under this arrangement, NCAS itself uses the Insurdata system to process claims for the Plans. Third, NCAS has entered into first-party administrator arrangements with a number of self-insured plans wishing to process their own claims. NCAS licenses the use of Insurdata services to those companies and provides support services for more than 4,500 insureds. Finally, NCAS operates its own insurance agency, NCAS Insurance Agency, Inc. which was created in 1987. Through this subsidiary, NCAS acts as a broker between its customers and reinsurance companies, receiving commissions on the sales it negotiates.

While the creation of NCAS was a reasonable effort to meet the challenges of a changing health care market, the execution of the plan to enter the TPA field was flawed. Several factors have hampered NCAS's success. High up-front costs for computer equipment and the Insurdata system rights, coupled with high interest payments on the debt undertaken to meet those costs, have contributed to NCAS's consistent annual losses.

NCAS has also been involved in litigation regarding a contract whereby it acted as the TPA for the United States Agency for International Development ("AID"). At the time the contract was negotiated, NCAS lacked experience with government contracts, and AID's contract proposal inaccurately characterized the quality of data that AID would provide. As a result, NCAS submitted an unrealistically low bid and began to lose money almost immediately after it was awarded the contract. Negotiations with AID eventually led to NCAS's submission of a claim in 1988 for equitable adjustment, which AID paid. A subsequent claim for 1989 was prepared by a different employee of NCAS who misused the limited timekeeping records available. When an audit revealed gross mathematical errors and unsupported statements in these later claims, AID refused to pay them. In the ensuing litigation,[8] which NCAS recently settled, the accuracy of the claim also was called into question. While it is beyond dispute that the later claims were flawed, it is also uncontested that NCAS's performance under the contract was superior and that the contract price did not come close to covering NCAS's true costs. Indeed, when NCAS declared its intention to withdraw at the end of the contract period—after the dispute over the claims had begun—AID insisted on extending the contract at an agreed rate that was several times the contract price. The clear loser throughout this dispute has been NCAS.

Questions have been raised about the sale of an NCAS asset to an employee. In 1988, NCAS purchased a subsidiary of the Michigan Blue Cross and Blue Shield Plan known as Blue Ribbon, Inc., after the Michigan Insurance Commissioner determined that the Plan no longer could operate subsidiaries. NCAS previously had licensed the use of Insurdata to Blue Ribbon, which functioned as a TPA. NCAS's decision to purchase Blue Ribbon was a reasonable one, based on the belief that NCAS could operate the TPA successfully. Following its acquisition by NCAS, Blue Ribbon became known as NCAS Midwest. The venture proved unprofitable. NCAS was reluctant simply to close NCAS Midwest, preferring instead to recover as much as possible of its investment. When no other buyer could be found, NCAS in 1991 agreed to sell NCAS Midwest to Joseph Crowley, former Vice President of Corporate Operations at NCAS, and Lee Hubbard and Chuck Baker, both employees of NCAS Midwest, for an amount exceeding the then-current book value of NCAS Midwest. Under the terms of the sale, NCAS accepted a promissory note from Crowley, Hubbard, and Baker, who were to repay the debt over a 10-year period, beginning one year after the sale was completed. While it is undisputed that there was a conflict of interest because of Mr. Crowley's position with NCAS, the nature of the transaction was fully disclosed and seemed reasonable in view of the absence of other business alternatives.

Despite NCAS's potential, it has consistently lost money. Indeed, members of the GHMSI Board expressed confusion as to why NCAS seemed to lose more money as it gained more business. As noted above, a substantial part of NCAS's losses are attributable to the high start-up costs associated with the system rights to Insurdata.

[8] The suit was a *qui tam* action brought by a former employee of NCAS who alerted AID to inaccuracies in the later claims. The Department of Justice intervened in the suit.

In addition, NCAS has an expensive lease which will not expire until 1994. NCAS's losses in 1986 were $1.5 million; in 1987, they were $1.8 million; and in 1988, they were $2.7 million. In 1992, NCAS lost approximately $1.5 million, with $1 million attributable to costs associated with the AID litigation.

Because NCAS can be a valuable adjunct to the core business, GHMSI intends to retain the subsidiary and seek ways to make it profitable. Since many of NCAS's fees are assessed on a capitated basis, NCAS's future profitability will be determined largely by the number of its customers and their insureds. Several anticipated improvements to NCAS's computer system should spur growth in the NCAS network. In addition, NCAS has renegotiated its relationship with Insurdata to improve its fees. NCAS expects improvements in its local TPA operation as a result of both cost-cutting measures and price increases to customers. Steps taken in 1992 to improve profitability included reducing staff, incentive payments, and telephone expenses, and adding furlough days. Marketing efforts for the local TPA will focus both on retaining existing customers and gaining as new customers mid-sized firms for which NCAS's claims processing system is particularly well-suited. In addition, NCAS will administer all of BCBSNCA's National Account Service Company ("NASCO") system processing business, about two-thirds of which was transferred to NCAS in 1992. Under current forecasts, NCAS is expected to generate a profit of $0.5 million in 1993.

J. First Continental Life and Accident Insurance Company

Effective January 1, 1992, GHMSI purchased First Continental Life and Accident Insurance Company ("FCL"), which provides both group life and group medical stop-loss insurance.[9] The acquisition was driven largely by the desire to facilitate Protocol's activities in the insurance field. Because FCL is licensed to sell insurance in 42 states and the District of Columbia, GHMSI expected this purchase to eliminate its need to expend millions of dollars annually on fronting fees paid to carriers in states in which GHMSI is not licensed to sell insurance.

FCL's business comes primarily from two managing general underwriters, which have continued their relationship with FCL since its acquisition by GHMSI. Intermediary Insurance Services, Inc. acts as the underwriter for medical stop-loss business that is written by Jefferson National Life Insurance Company and reinsured by FCL. Under the terms of its contract to acquire FCL, GHMSI agreed to pay Jefferson Life a 6 percent fronting fee on business written by Jefferson and reinsured by FCL during the first two years of GHMSI's ownership. The Deyhle Group underwrites FCL's direct medical stop-loss coverage.

FCL is expected to show a gain of $0.5 million, on a GAAP basis, in 1992; similar results are anticipated in 1993. GHMSI is actively working to address the business issues presented by FCL, including the question of whether FCL fits with the current focus on the core business.

K. National Capital Reinsurance Co., Inc. of Barbados National Capital Reinsurance. Ltd. of Ireland

In 1987, GHMSI formed National Capital Reinsurance Co., Inc. of Barbados ("NCRe Barbados") to provide reinsurance to outside clients as well as many of GHMSI's subsidiaries. The decision to offer reinsurance was based in part on a perceived need to offer coverage for risks being administered by third-party administrators, including NCAS.[10] The reinsurance business, however, is complex and GHMSI lacked expertise in this area. Management of the business was entrusted first to Robert Weimer, an actuary who had little experience in the reinsurance industry, and later to David Kestel, whose specialty was marketing.

In 1991, Mr. Kestel decided to wind down NCRe Barbados and replace it with National Capital Reinsurance, Ltd. of Ireland (hereinafter referred to collectively as "NCRe"). Whatever the business justification for the creation of the Irish company, NCRe has not been profitable for GHMSI. The result, of course, was that GHMSI, as the parent company, ultimately bore the risks.

From a financial standpoint, NCRe's losses are largely attributable to its involvement with Protocol, which became its largest customer. NCRe assumed risk for Protocol's international business and for Protocol's United Way Association contract. Even more importantly, NCRe provided first dollar coverage and stop loss insurance for the B'nai B'rith contract.

NCRe has incurred a cumulative loss since its inception. In 1992, NCRe's losses increased dramatically as a result of the B'nai B'rith account. The projected loss for

[9] FCL's part of GHMSI's Insurance Division.

[10] NCRe insured risks only from U.S. companies.

1992 of $6.9 million is primarily attributable to the B'nai B'rith contract. In addition, NCRe will recognize in 1992 expected future additional losses of some $12.1 million resulting in a total booked loss for 1992 of $19 million.

During 1992, NCRe instituted a number of remedial measures to improve its performance, including a reduction of its staff side from nine to five employees and an imposition of a 10 percent salary reduction. Nevertheless, it became clear that the companies should be dissolved. The offices in Barbados and Ireland were therefore closed in October 1992. Of NCRe's 14 product lines, seven will be cancelled; two have been ceded to another carrier, effective July 1992; and four are renewing through other carriers.

L. Protocol. Inc.

Formed in June 1986,[11] as a joint venture with the Medlantic HealthCare Group, Inc. ("Medlantic"), Protocol's initial purpose was to market to embassies and other international organizations health care coverage for individuals residing in the United States.

Protocol offered its customers a number of products and services: Blue Cross coverage; claims processing; special services such as managed care and hospital arrangements; and administrative services, such as billing, enrollment, collection and customer service.[12] The risk on the insurance written by Protocol was carried by a number of carriers, including National Capital Reinsurance Limited ("NCRe"), a wholly-owned subsidiary of GHMSI formed under Irish law.

In September 1987, some eighteen months after Protocol's formation, Mr. Gamble advised the Board of Trustees that the company had been well-received by the diplomatic and international communities; that Protocol had already penetrated 20 percent of the market; and that the losses as of June 1987 had been below those projected. Regrettably, Protocol's revenue base proved to be inadequate to support the costs of highly-customized insurance products. Consequently, by September 1988, Protocol had generated losses of $1.2 million through December 1987 with projected losses of more than $900,000 for 1988 and 1989.

In an effort to generate revenues, Protocol negotiated a contract with B'nai B'rith, which was executed by GHMSI on July 31, 1990, for the provision of certain health benefits to B'nai B'rith members. Notwithstanding the size and nature of the contract, it was not presented to the GHMSI Board prior to execution. Protocol was to administer the five-year contract, which became effective in January 1991. The contract guaranteed commission payments to B'nai B'rith of approximately $2 million per year, and additional administrative fees of approximately $1 million per year. The B'nai B'rith arrangement, which is Protocol's largest account, proved to be one of the most complex associations, from a health insurer's point of view, in the United States. Protocol simply was not equipped to handle the business, which is high-risk and labor intensive. Massive underwriting losses were accompanied by losses of equal magnitude on the administrative expenses side of the ledger.

Primarily because of the B'nai B'rith account, Protocol lost $4.7 million in 1991 on net revenue of $2.2 million. For 1992, Protocol is expected to post an operating loss of approximately $7 million most of it attributable to B'nai B'rith. Protocol will charge against 1992 income approximately $7 million consisting of all future contingent administrative losses for 1993, 1994, and 1995 on the B'nai B'rith contract. NCRe will record in 1992 contingent risk losses for that period of up to $12 million for this contract.

GHMSI plans to close Protocol by the second quarter of 1993. All customers have been advised that contracts will not be renewed, and all contracts except B'nai B'rith have been transferred to BCBSNCA for processing until expiration. In late December 1992, GHMSI notified B'nai B'rith of its intention to exercise its right to terminate the contract. Discussions between attorneys representing GHMSI and B'nai B'rith are now taking place.

II. Federal Programs

A. *NTEU Contract*

---

[11] On June 25, 1986, the joint venture was formed as a partnership. GHMSI's 50 percent interest in the partnership was held by The GHMSI Partnerships, Inc. Pursuant to an agreement effective January 1, 1988, The GHMSI Partnerships, Inc. acquired Medlantic's 50 percent interest of Protocol. Concurrent with the effective date of the agreement, the partnership dissolved and its operations became those of The GHMSI Partnerships, Inc. In 1988, The GHMSI Partnerships, Inc. name was changed to Protocol, Inc.

[12] Protocol Administrative Services, Inc., a wholly-owned GHMSI subsidiary, was formed on April 19, 1991. This subsidiary has not had any activity.

For many years, BCBSNCA has provided health insurance to employees of the federal government. It has done so by participating in the Federal Employees Health Benefits Program ("FEHBP"), which is administered by the Office of Personnel Management ("OPM"). BCBSNCA's role within FEHBP is twofold. First, it participates in the Federal Employees Program ("FEP"), the nationwide program administered by the national Blue Cross Blue Shield Association. Second, BCBSNCA serves as the administrator and underwriter for various FEHBP Plans sponsored by unions and other employee organizations.

The employee organization component of the FEHBP business has for some time been perilous for private insurers such as BCBSNCA because of OPM regulations. With the exception of OPM not allowing the recovery of reasonable administrative expenses incurred for such programs, BCBSNCA had full knowledge of these regulations and the inherent risks. BCBSNCA has worked hard to overcome these obstacles, and it has enjoyed some success in its FEHBP activities. A notable exception was the FEHBP Plan sponsored by the National Treasury Employees Union ("NTEU"). BCBSNCA began serving as NTEU's underwriter and administrator on January 1, 1989. By the end of 1992, the NTEU contract will generate an estimated cumulative loss of $20 million. BCBSNCA terminated the NTEU contract effective December 31, 1992.

To understand the cause of the $20 million loss, one must examine NTEU's performance chronologically. BCBSNCA began providing coverage to NTEU on January 1, 1989. At the time it set rates for 1989, in the spring of 1988, it obviously had no experience as NTEU's underwriter. Therefore, in developing its rate structure BCBSNCA was forced to rely on summary data developed by NTEU's former underwriter, Mutual of Omaha. Based on this data, BCBSNCA imposed a 40 percent rate increase for 1989.

Ideally, BCBSNCA would have been allowed to evaluate the experience in 1989 before setting rates for 1990. Under OPM regulations, however, it was required to submit final proposed rates by May 31, 1989. In practical terms, the May 31 requirement meant that, once again, BCBSNCA was forced to develop rates essentially with blinders on. At the time it developed its 1990 rate structure, the results from 1989 were so limited as to be virtually useless. Based on those limited results, and on Mutual's summary data from 1988, BCBSNCA projected losses in 1989 and therefore imposed a further 48 percent rate increase in 1990.

As it turned out, the projected losses were not realized; the 1989 results were favorable. Despite the 40 percent rate increase, NTEU's rates had remained in the lower one-third of all FEHBP Plans. As a result, plan enrollment had increased 71 percent and there was at the end of the year a net surplus of $865,585 in reserves. Unfortunately, at the time it set its 1990 rates BCBSNCA had no way to predict these results.

The cycle of blind rate-setting was repeated in early 1990. Because of the May 31 rule, BCBSNCA was required to submit its rates for 1991 before the effects of the 1990 rate increase had become apparent. When the 1991 rates were submitted in May 1990, BCBSNCA and OPM were aware only of the 1989 actual surplus and it was projected that 1990 would also end with a surplus. Because of the surplus, OPM denied BCBSNCA's request for a modest 5-6 percent rate increase for 1991. Rates remained unchanged in 1991.

As 1990 results progressed, however, it became apparent in 1991 that the 48 percent rate increase for 1990 had actually resulted in a cumulative loss of $1.2 million instead of a surplus, as projected. The 1990 rate increase had made NTEU more expensive than the FEP and other coverage available to federal employees. As a result, membership dropped 22 percent and the Plan's composition changed dramatically as sick members remained and healthy members left.[13]

By early 1991, as BCBSNCA began developing proposed rates for 1992, it had become clear that, because of the poor 1990 results and the absence of a 1991 rate increase, a substantial increase in 1992 rates would be necessary. The 1991 projected cumulative losses were then estimated to be nearly $8 million. Moreover, because rates had not increased for 1991, NTEU enrollment had actually increased by 18 percent; BCBSNCA had no ability to evaluate the financial impact of that substantial growth. In the spring of 1991, BCBSNCA recognized that the account was becoming a problem. With a projected cumulative loss by year end and an 18 percent increase in enrollment, serious consideration was given to cancelling the account effective December 31, 1991. Instead, BCBSNCA decided to stay with the Plan for an-

[13] When selecting health insurance, healthy persons are generally more price-sensitive than sick persons, who are more concerned with coverage.

other year in an effort to reverse the downward cycle and move toward future profitability. It imposed a 40 percent rate increase for 1992 in the expectation that the new rates would lead to a 20 percent decline in the Plan's membership but would at least avoid an underwriting loss in 1992. That would set the stage for a recovery in future years.

When the results of the 1991 open season were finalized in the Spring of 1992, however, the downward spiral of enrollment accelerated as the 40 percent rate increase led to a 55 percent decline in the Plan's membership. Although part of this decline is attributable to the rate increase, another significant factor was OPM's allocation of the premium between the employee and the employer for 1992. The overall premium paid to BCBSNCA increased 40 percent for 1992, but the share contributed by the employee more than doubled, driving out healthy members in droves and leaving the Plan with a smaller, sicker membership than before.

In the spring of 1992, recognizing that the downward spiral was essentially irreversible, BCBSNCA made the decision to terminate the NTEU contract effective December 31, 1992. It also took immediate—and bitter—steps to blunt the effects of the NTEU loss by imposing budget cuts of $7-$8 million. NTEU was unable to secure another underwriter, and accordingly no longer exists as a FEHBP Plan.

To some extent, the retention of a disproportionate number of unhealthy people in the NTEU account can be blamed on the generous prescription drug benefits offered by the NTEU Plan. Those benefits served as a magnet for chronically ill subscribers.[14] But a thorough examination of the facts surrounding the NTEU contract reveals that, given the dramatic swings in rates and resulting enrollment changes, BCBSNCA simply could not manage around the uncertainties created by the OPM regulations with regard to open season, the timing of rate proposals, and the calculation of the employee's contribution. BCBSNCA has now terminated the NTEU contract effective December 31, 1992 and will record the cumulative losses in 1992.[15] BCBSNCA obviously will move with extreme caution in pursuing any new employee organization plans within the FEHBP that have open enrollment features and benefits similar to NTEU.

APPENDIX C

BIOGRAPHICAL INFORMATION ABOUT CURRENT GHMSI TRUSTEES

1. *Ira Laster Jr.* has served as a Board member since 1985. Between 1970 and 1985 he served as a Board member of Medical Service of the District of Columbia, ("MSDC") one of GHMSI's predecessors. Mr. Laster serves as Senior Program Coordinator with the Environmental Division in the Office of Regulatory Affairs at the Department of Transportation. He has been a Department of Transportation employee since 1970, and before that time served as a health planning consultant for the United Way.

Mr. Laster is a Fellow of both the Society for Public Health Education and the American Public Health Association. He has been a member of the Metropolitan Washington Public Health Association since 1971 and served as its president from 1984 to 1985. He has also served on other boards, including that of the United Way of the National Capitol Area.

Mr. Laster was born in Chatham County, North Carolina and holds a Ph.D. in Public Health and Education from the University of North Carolina at Chapel Hill. He earned his B.S. and M.S. in Public Health at North Carolina Central University, where he was an assistant professor from 1966 to 1968. He is married, and has two daughters.

2. *Robert C. Mayer* has served as a Board member since 1985. Between 1975 and 1985 he served on the Board of MSDC. Mr. Mayer has practiced law with the firm Woll & Mayer since 1954. From 1949 to 1954, he served as the Executive Secretary to the Airport Operators Council. He has been a commissioned officer in the United States Naval Reserve since 1943.

Mr. Mayer was born in Washington, D.C. and earned bachelor of science degrees from the United States Merchant Marine Academy and Georgetown University. He holds a J.D. from George Washington University. Mr. Mayer, a widower, has two daughters and three sons.

---

[14] Despite the demonstrated problems with the prescription benefits, NTEU was unwilling to modify the coverage.

[15] BCBSNCA had another, even larger, FEHBP in which it had been able to resolve the underwriting issues, but that account was also cancelled effective December 31, 1991 because of concerns that there could be losses in the future.

3. *Floretta Dukes McKenzie* has served as a Board member since 1992. Between 1991 and 1992 she served on the Board of Blue Cross Blue Shield of the National Capital Area ("BCBSNCA"). Dr. McKenzie has been the president of The McKenzie Group, a comprehensive educational consulting firm, since 1988. From 1981 to 1988 Dr. McKenzie was Superintendent and Chief State School Officer for the District of Columbia Public Schools. She has also served as Deputy Assistant Secretary, Office of School Improvement, U.S. Department of Education; U.S. Delegate to UNESCO; Deputy Superintendent of Schools, Montgomery County Public Schools; and Assistant Deputy Superintendent, Maryland State Department of Education. In the spring of 1990, Dr. McKenzie was a distinguished visiting professor at Harvard University's Graduate School of Education.

In addition, Dr. McKenzie serves on the boards of The Acacia Group, the National Geographic Society, Potomac Electric Power Company ("PEPCO"), Riggs National Corporation, The George Washington University, WETA public television, Reading is Fundamental ("RIFO"), the Boy Scouts of America, and other organizations.

Dr. McKenzie was born in Lakeland, Florida and holds an E.D.D. from George Washington University. She earned her B.S. from D.C. Teachers College and her M.A. from Howard University. In addition, she holds honorary degrees from Catholic University, Trinity College, Bowie State University, Georgetown University, and Williams College, and has been awarded the Medal of Excellence by Columbia Teachers College. She is divorced and has one daughter and one son.

4. *Victor E. Millar* has served as a Board member since 1987. Mr. Millar has been the chairman and CEO of PMS Management International since 1990. From 1987 to 1989, he was the chairman and CEO of Saatchi & Saatchi Consulting. Prior to that time, he acted as managing partner of Arthur Andersen & Company from 1958 to 1986.

Mr. Millar's other board memberships include Information Technology Resources Center in Chicago and the New York City Partnership.

Born in Anaheim, California, Mr. Millar earned his B.S. and M.B.A. at the University of California at Berkeley. He is married and has two daughters and two sons.

5. *Charles T. Nason* has served as a Board member since 1991. He is chairman of The Acacia Group, a financial services firm. He served as a managing director at The Acacia Group from 1977 to 1988 and was its president and CEO until July 1989, when he became chairman. Before joining The Acacia Group, he was a financial planner and consultant with Metropolitan Life Insurance Company 1971 to 1977.

Mr. Nason is a trustee of the Federal City Council and a director of the Washington Board of Trade and the Washington Financial Services Council, and holds other directorships as well.

Born in Pittsburgh, Pennsylvania, Mr. Nason received his B.A. from Washington and Jefferson College in 1968 and his M.B.A. from the University of Pittsburgh in 1969. He is married and has two daughters.

6. *Peter F. O'Malley* served on the Board between 1986 and 1989, and rejoined the Board as Chairman on October 1, 1992. Mr. O'Malley is the founder of the law firm of O'Malley & Miles, a 30-plus attorney firm based in the Washington area and specializing in real property and commercial transactions, estates and trusts, zoning and land use, administrative law, and litigation.

Mr. O'Malley is a director of PEPCO, Potomac Capitol Investments, The Capital Centre, and Legg Mason, Inc. His broad public service includes two periods as the Chairman of the Board of Regents of the University of Maryland system, memberships on the Board of Trustees of Mount St. Mary's College and the Federal City Council, a directorship on the Washington/Baltimore Association, and the presidency of the Washington Board of Trade. He has also served as the president of Washington's professional hockey team, the Capitals.

Mr. O'Malley holds a B.S. degree from Mount St. Mary's College and an LL.B. from Georgetown University Law Center. He is married and has a son and four daughters.

7. *Lutrelle F. Parker* has been a member of the Board since 1985. Between 1977 and 1985 he served as a member of the Board of Group Hospitalization, Inc. ("GHI"), one of GHMSI's predecessors. Mr. Parker is a retired member of the Board of Appeals of the Patent and Trademark Office, having served in that position since 1983. Between 1980 and 1983, he was an acting member of the Board of Appeals. Prior to his appointment to the Board of Appeals, Mr. Parker was the deputy commissioner of patents and trademarks from 1975 to 1980, and.twice during that time served as the acting commissioner. From 1970 to 1975, he served as Examiner-in-Chief for and as a member of the Board of Appeals.

Mr. Parker, a retired Captain in the U.S. Naval Reserve, has served in other governmental positions, including service as Chairman of the Arlington County Planning Commission and, presently, as a member of the Board of Zoning Appeals. He has served on numerous boards of directors, including the Board of Visitors for George Mason University.

Mr. Parker holds a B.S. from Howard University and a J.D. from Georgetown University Law Center. He is also a graduate of the U.S. Naval Reserve Midshipman School of Cornell University and attended the Naval War College in Newport, Rhode Island. He is married and has three sons.

8. *Benjamin S. Pecson, M.D.* has served as a member of the Board since 1985. Between 1983 and 1985 he served on the Board of MSDC. Dr. Pecson, a physician, has had a family and general practice in District Heights, Maryland since 1957.

Dr. Pecson has served as the president of the Prince George's Medical Society and as a member of numerous other medical societies, including the American Academy of Family Practice, the American Medical Society, and the District of Columbia Medical Society. He has also served as the chairman of the board of directors of the Prince George's Hospital and Medical Center, and as a director for the Doctor's Hospital of Prince George's County and the Prince George's County Hospital Commission, among other affiliations.

Born in Manila, the Philippines, Dr. Pecson holds his undergraduate degree from the University of the Philippines and his M.D. from the University of Santo Tomas in Manila. He is married and has two sons and two daughters.

9. *Robert Petersen* has served as a member of the Board since 1985. Between 1979 and 1985 he served on GHI's Board. He has been the vice president of the Maryland-D.C. AFL-CIO since 1975 and has been active in organized labor activities in the D.C. area since 1964.

Mr. Petersen also serves on the boards of the United Way, the Workplace Health Fund, and the Labor Agency of Metropolitan Washington, among others.

Born in Birmingham, Alabama, Mr. Petersen holds degrees from the University of Florida, Prince George's Community College, and George Meany Center (Antioch). He is married and has one son and one daughter.

10. *Mallory Walker* has served as a Board member since 1989. Mr. Walker has been the president of the mortgage banking firm of Walker & Dunlop since 1976. He has been with the firm since 1963 and has also served as vice president, director, and executive vice president.

Mr. Walker is a director of the Greater Washington Board of Trade and a trustee of the Greater Washington Research Center and the Federal City Council. He also serves as a director of Fannie Mae and on the board of governors of the Mortgage Bankers Association.

Born in Washington, D.C., Mr. Walker attended the University of Virginia. He is married and has two sons.

11. *David S. Wiggin* has served as a Board member since 1987. He has been the Senior Vice President and Chief Financial Officer of Holy Cross Hospital of Silver Spring, Maryland since 1977. From 1971 to 1977, he was the Treasurer of the Memphis and Shelby County Hospital Authority and, before then, a member of the professional staff of Touche Ross & Company.

Mr. Wiggin's other activities include memberships on the boards of the Montgomery County Hospital, Inc. and the Society for Health Assurance, Research & Education, Inc.

Born in Newark, New Jersey, Mr. Wiggin holds B.B.A. and M.B.A. degrees from Memphis State University and is a Certified Public Accountant. He is married and has two sons and a daughter.

Prepared Statement of Mr. O'Malley

Mr. Chairman, Members of the Subcommittee, my name is Peter O'Malley. On October 1, 1992, I accepted the invitation of the Board of Trustees of Group Hospitalization and Medical Services, Inc. to join it as the Chairman. It was intended by me, and the Board, to be for a limited time to assist during a period of transition.

I take my Board responsibilities very seriously and was reluctant to undertake that assignment because of other commitments in my professional life. Initially, I recommended that the Board consider other candidates and I suggested several individuals. At the urging of the Board and Ben Giuliani, GHMSI's Chief Executive Officer-elect, and after being assured that the Board would remain fully involved and that reforms I had earlier proposed had or were about to become a reality, I accept-

ed the challenge. The charge accompanying that challenge, however, was far different from the task at hand.

In my discussions with the Board and Mr. Giuliani, three primary areas of responsibility were identified for the position for which I was being solicited. First, I would provide leadership in communicating with and preparing the Board for the sweeping changes then underway. In addition, I would assume responsibility for regulatory matters. And finally, I would supervise the Company's cooperation in connection with the inquiry of this honorable Subcommittee. My assumption of these duties would allow Mr. Giuliani to focus entirely on the operations and the restructuring of GHMSI, matters to which he and the Board were firmly committed.

Within days of assuming my responsibilities, and following visits to the Virginia Insurance Commissioner and from the Blue Cross and Blue Shield National Association, it became clear that subsidiary losses had severely impacted GHMSI's ability to meet the requirements of both the Virginia Insurance Commissioner and the National Association.

The Virginia Insurance Commissioner advised me of his concern about GHMSI's position with regard to Virginia's regulatory reserve requirements. Likewise, the National Association had placed GHMSI on its watch list and had threatened action which went to the core of the Company's ability to do business.

This information was promptly shared with the entire Board. Needless to say, in view of the significance and complexity of these issues, efforts to resolve them have required a virtual around-the-clock commitment.

Almost simultaneously, Dr. Duvall advised me of a call from Mr. Norwood Davis, CEO of the Blue Cross and Blue Shield Plan of Virginia, inquiring whether there was merit to discussing an affiliation with the Virginia and National Capital Area Plans. During initial visits, we learned that a similar proposal regarding regional affiliation had been explored several years earlier.

Given the apparent benefits of the concept, particularly the subscriber benefits and cost reductions, this development was immediately reported to the Board. After its thorough discussion with Mr. Davis regarding financial capability, organizational culture and commitment to subscribers' interests, the Board of Trustees authorized the necessary due diligence to evaluate an affiliation.

This too has been a taxing exercise. Everyone connected with GHMSI has worked exhaustively to understand and evaluate the consequences of this proposal and its impact on our mission to serve subscribers as the insurer of last resort in the metropolitan D.C. area.

Concurrently, Mr. Giuliani and senior management were successful in eliminating 24 of GHMSI's 45 subsidiaries and in conducting the evaluation process which promises to lead to the sale or elimination of up to 10 more subsidiaries, so that GHMSI's focus will return to the core business. The Board has remained fully informed of, and diligently engaged in, this effort.

This process has required tremendous efforts on the part of many dedicated people at GHMSI; they have all worked very hard to achieve the critical goals and to follow the clear present direction from management.

Externally, however, the view is less clear. As the Subcommittee is aware, this hearing is taking place in the midst of sensitive discussion between GHMSI and Blue cross and Blue Shield of Virginia regarding the mentioned affiliation. The market place is attuned and volatile. Capital and time are our most precious and limited assets. Significantly, the traditional sources of capital are not readily available to non-stock, non-profit entities such as GHMSI, and the regulators largely control the time we have to work towards a solution.

Mindful of these factors, the Board and senior management have been working intensely in connection with the proposed affiliation.Their purpose has been to identify and understand the consequences of the transaction so that it will be structured in a manner which will not only be in the best interest of subscribers, employees and providers but will also win the necessary approval of GHMSI's multiple regulators.

While such issues persist, I can report that our discussion with Virginia are in a constructive phase and we are hopeful that an affiliation can move forward on a sound business basis. If we succeed GHMSI, Blue Cross and Blue Shield of Virginia, the National Association and the cooperating regulators will have much to be proud of. As GHMSI continues with its restructuring and pursues the affiliation, it has at least $90 million in cash and Government and Corporate securities and $300 million set aside on its balance sheet to cover unpaid claims.

Affiliation, however, is not a certainty. We therefore have been working simultaneously on a program to assure continued service to our subscribers. This also will require continued cooperation from the regulators to whom GHMSI must answer.

We have chosen at every stage to attempt to accommodate the needs of those regulators and to involve them in the process. In Virginia, with the assistance of the National Association, we achieved a temporary solution to the need to maintain our reserve levels in an amount equal to 45 days worth of claims by obtaining a $15 million surplus note from the National Association. Additionally, we purchased reinsurance for our Virginia business at a cost to GHMSI of approximately $2.8 million.

GHMSI must chart a course for the future that is not only honorable but realistic. Obviously the Virginia affiliation is a very promising opportunity. If, however, that transaction cannot be accomplished or cannot be accomplished promptly, GHMSI must be prepared to well serve subscribers needs through other means. To that end, GHMSI's senior management has developed, and the Board has approved, a comprehensive business plan for 1993 and beyond.

The business plan reflects the advice of numerous talented consultants and our new energetic Chief Financial Officer. It calls for the continuing divestiture of those subsidiaries which are not directly related to our core blue Cross and Blue Shield business. The business plan further emphasizes the previously recognized need to cut costs and expenses. And it projects revenues in 1993 of $1.7 billion and a resulting increase in statutory reserves of $13.6 million.

GHMSI's self-examination process, in combination with focused management; the sound advice the Board has received from its superior consultants; and the Board's firm resolve to follow that advice, all suggest that the future can belong to GHMSI.

Costs and expenses have been sharply reduced; unnecessary and underperforming subsidiaries have been or will shortly be sold or eliminated. The adventuresome, unfocused corporate culture depicted in the Staff's historical analysis certainly no longer exists. Progress has been made.

Since assuming my responsibilities, at the Board's direction and on its behalf, I have emphasized the needs of subscribers, employees and providers. I have continuously stressed the importance of integrity, accuracy and speed in dealing with the informational needs of our regulators and this Subcommittee.

Over the last 4 months with the Board's strong encouragement, the internal restructuring at GHMSI and the related effort to gain control of costs and expenses is on track. Things are on the mend. Intense, continuous attention is being focused on the important challenges with which we are confronted. Priorities have been established and are being strictly adhered to.

GHMSI's often painful self-examination, performed under the spotlight generated by this Subcommittee, has shaken the institution to its core. Mr. Chairman, the Subcommittee can be assured that the Board and current management are committed to honoring the requirements of GHMSI's Charter and to insure that the Company well serves this community. Surely this workout deserves being seen through to success.

**STATEMENT OF JOHN A. DONAHO, INSURANCE COMMISSIONER
BEFORE THE UNITED STATES SENATE,
PERMANENT SUBCOMMITTEE ON INVESTIGATIONS
JANUARY 26, 1993**

Mr. Chairman:

You have requested that I provide you with an update on the regulatory situation with Blue Cross and Blue Shield of Maryland (BCBSM). Since the September, 1992 hearing on the Maryland Plan there have been significant changes in BCBSM's organization and management as well as in BCBSM's attitude and relationship with the Maryland Insurance Division.

Before I comment on these developments, Mr. Chairman, I want to express to you my sense of the important impact of your investigations and hearings on the Blue Cross and Blue Shield Plans across the United States.

The thorough investigation conducted by your able staff, and the public hearings held by you, exposed numerous financial and management failures with respect to BCBSM. Without this public exposure, my staff and I would, to this day, be unaware of the real problems that existed in the Maryland and D.C. Plans.

As a result, I fully support these hearings and your continued efforts to review other Blue Cross Plans, including the National Blue Cross Blue Shield Association.

At this point, for the first time in several years, BCBSM is heading in the right direction. The company has finally begun to dismantle wasteful and costly subsidiaries and has begun to devote its energies to the health care insurance business for which it was created in the first place. This is a very positive development

which I encourage and which our proposed legislation would actually require.

Your efforts have alerted regulators and public officials to the difficulties and challenges we all face in exercising proper oversight of the plans. No doubt management of these plans is even more cognizant of its responsibility to ensure efficient and accountable delivery of health services to the public. Along with 1.5 million subscribers and other Maryland citizens I wish to thank you, Committee Members and staff, for the catalytic awakening delivered to Blue Cross and Blue Shield of Maryland and for the opportunities your hearings have provided to us as regulators to do our job better.

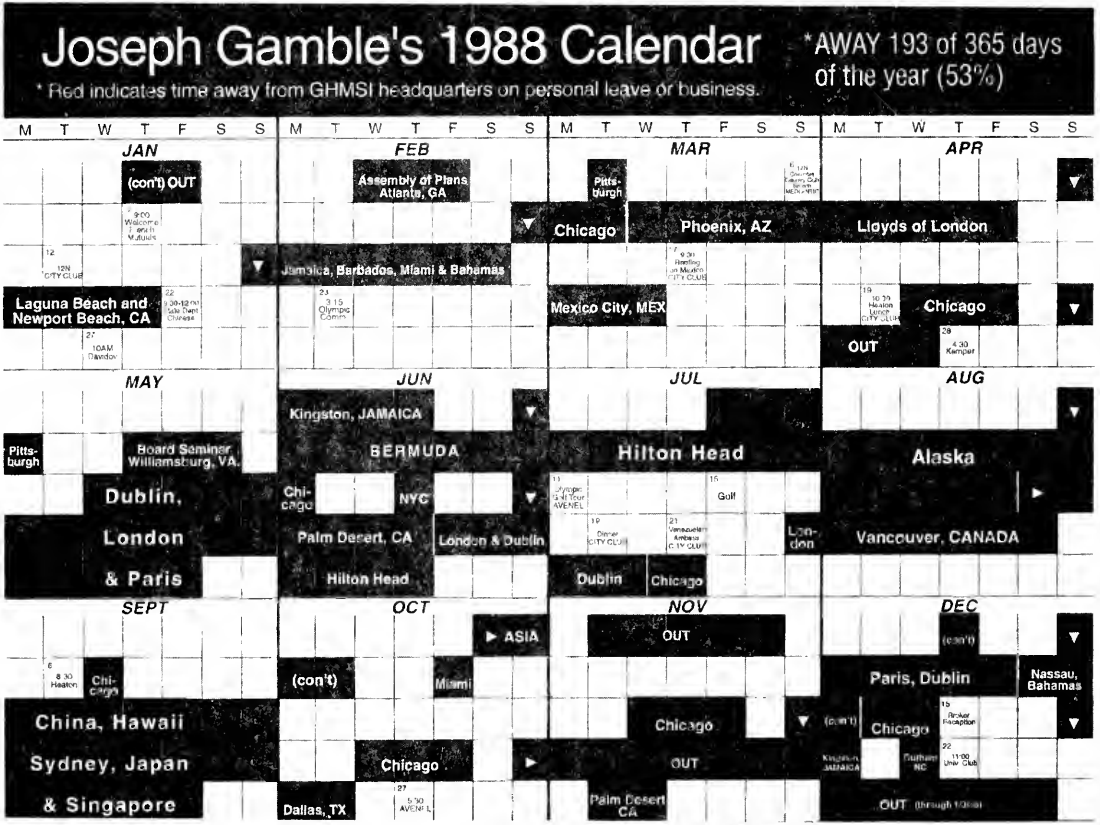
Almost immediately after the September Hearings the BCBSM Board appointed a new Chairman, commissioned a special 9 week investigation by a Committee of the Board into specific operational areas, discontinued certain extravagant spending practices including the Orioles skybox, Preakness tent, certain bonuses, etc., and initiated more open and frank communications with the Maryland Insurance Division. More recent board actions have included the exit of the former president and CEO, Mr. Carl J. Sardegna, and the senior management team, the dissolution of approximately one dozen subsidiaries, the establishment of new board committees on finance, service and public affairs, and a search for a new permanent president and CEO.

The Insurance Division is now receiving, or is about to receive, monthly reporting on complaint resolution, claim service,

risk versus non-risk business, reserves and liquidity, and other financial reporting issues. Primary to the Division is the introduction of new legislation to address many of the recommendations of this Committee's September report, including more realistic minimum surplus requirements, audited financial statements, freer access to internal and external financial communications, more notification of oversight on formation of subsidiaries and organizational changes, and the composition and tenure of the board of BCBSM. Attached is a copy of our Departmental Legislation HB 238 which will be considered by the Maryland Legislature shortly and which enjoys the support of Governor William Donald Schaefer.

Another significant development has been the initiation of a dialogue with the National BCBS Association and the sharing of basic concerns of the division and the Association with respect to the financial condition and operations of Blue Cross and Blue Shield of Maryland as well as the D.C. Blues.

Lest we become complacent with these initial steps, I must add that BCBSM and the Insurance Division still have a long way to go to restore BCBSM to its former stature and solidity. Service will be a long term problem, accounting issues still need to be resolved, a new CEO must be installed, strong legislation must still be passed, expenses must be controlled, and the Division must continue to strengthen its oversight of the Plan's recovery. I am aware of the attention of other organizations, officials, and the NAIC in how we address and resolve the difficulties of the Maryland and the D.C. Plans. In that vein, I encourage you and the Committee to continue your efforts to ensure that Blues Plans across the country are functioning properly and are structured to deliver quality health services to citizens everywhere.

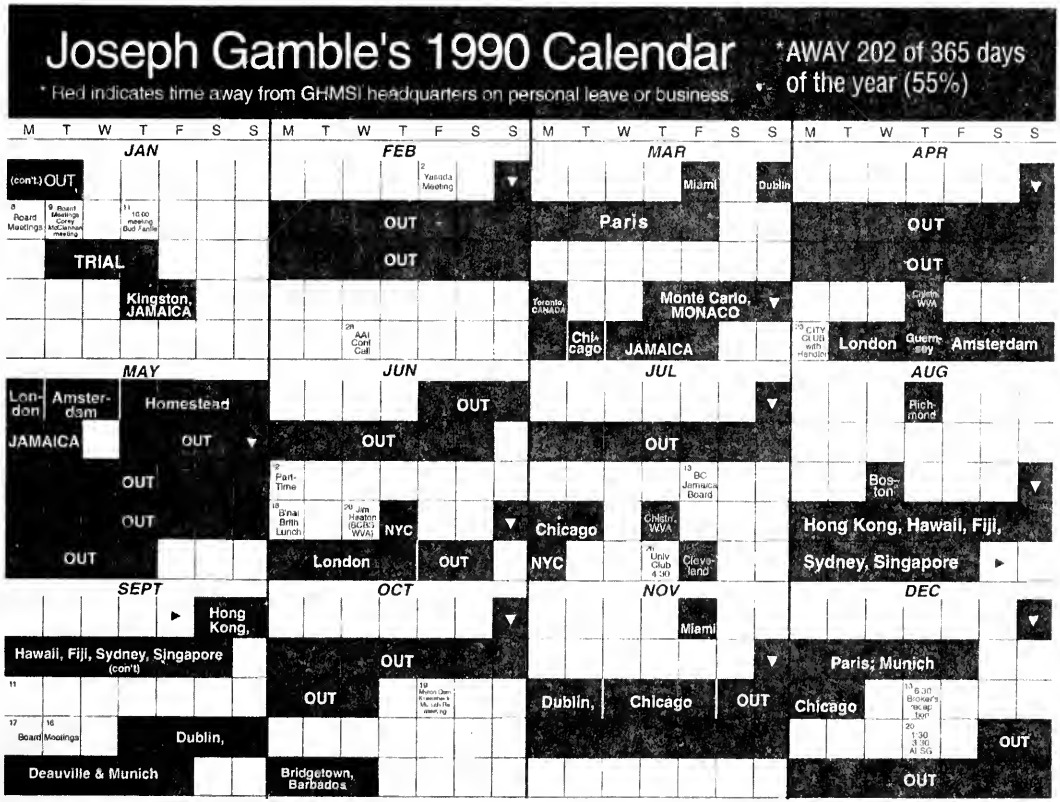


Senate Permanent Subcommittee on Investigations

EXHIBIT # 11 (Part 1 of 3)

Senate Permanent Subcommittee on Investigations

EXHIBIT # 11 (Part 2 of 3)



Senate Permanent Subcommittee on Investigations EXHIBIT # 11 (Part 3 of 3)

MHA
Maryland
Hospital
Association

January 22, 1993

The Honorable Sam Nunn
United States Senator
United States Senate
Permanent Subcommittee on Investigations
Russell Office Building
Room 100
Washington, D. C. 20510-6250

Dear Senator Nunn:

We would like to express our appreciation for your examination of the Blue Cross and Blue Shield Plans. In the case of the local Plans, your review has been timely and undoubtedly helped avert deterioration of their performance. Having strong stable Blue Cross and Blue Shield Plans is essential to providing financial access to needed health services. Traditionally, Blue Cross plans have been responsive to broad-based insurance needs of our citizens. The consequences would be disastrous for individuals, businesses, hospitals and other providers if they were unable to serve their subscribers as was the situation in West Virginia.

Both local Plans have now undergone dramatic restructuring and the subcommittee's work certainly played an influential role. Based upon our experience locally, we would urge you to initiate a process to screen other plans and major insurers and conduct full reviews where less than sound insurance practices are identified.

The consultant retained by the Maryland Hospital Association, Walter Schneckenburger has orally reviewed our findings on the Blue Cross and Blue Shield of Maryland Plan with the subcommittee staff. The key points are:

- The Plan can continue paying claims for the next year without major difficulty.
- Payment of claims in the long run can only be assured if the practice of exchanging subscriber cash for capital stock and loans to affiliates is stopped.

-more-

1301 York Road
Suite 800
Lutherville, MD
21093-6087
(410) 321-6200
FAX (410) 321-6268

- Over the last six years, capital losses have exceeded $125 million and the investment in affiliates exceeded 3 percent of earned premiums.

- Realistic valuation of assets will reduce reserves to low levels.

- At the end of 1985, cash, short-term investments and bonds represented 82 days of total claims incurred and underwriting expense, while at the end of 1991, this number was 30 days.

Moorhead Vermilye, chairman of the Maryland Hospital Association Board of Trustees and Calvin Pierson, president of the Maryland Hospital Association met with Frank A. Gunther, board chairman, and William A. Beasmen, acting CEO, Blue Cross and Blue Shield of Maryland, on January 14, 1993. The session was most productive. The issues were readily acknowledged and the steps being pursued to correct the problems were discussed. Our representatives were impressed with the sincerity and dedication of the new leadership in focusing on the fundamental business of Blue Cross and Blue Shield of Maryland and to dealing promptly with the issues at hand.

Our work is still underway regarding Blue Cross and Blue Shield of the National Capital Area. The information on file with the Maryland Insurance Commissioner has been evaluated and the audited financial statements reviewed. Mr. Schneckenburger is in the process of finalizing his report. When we complete our evaluation of the D.C. Plan, we will seek an opportunity to present our assessment to them and we will keep you apprised as to when we can share our findings with you.

We hope you understand our desire to share our findings with the Blue Cross Plans in advance of any outside discussion of them. We have had a long and positive relationship with these organizations. Toward this end, we want to be helpful in the Blue Cross Plans' returning to strong community service organizations.

Thank you for your cooperation and that of your staff in our review of the financial status of the Maryland and District of Columbia Blue Cross and Blue Shield Plans.

Sincerely,

Edgar Lawrence
Executive Vice President

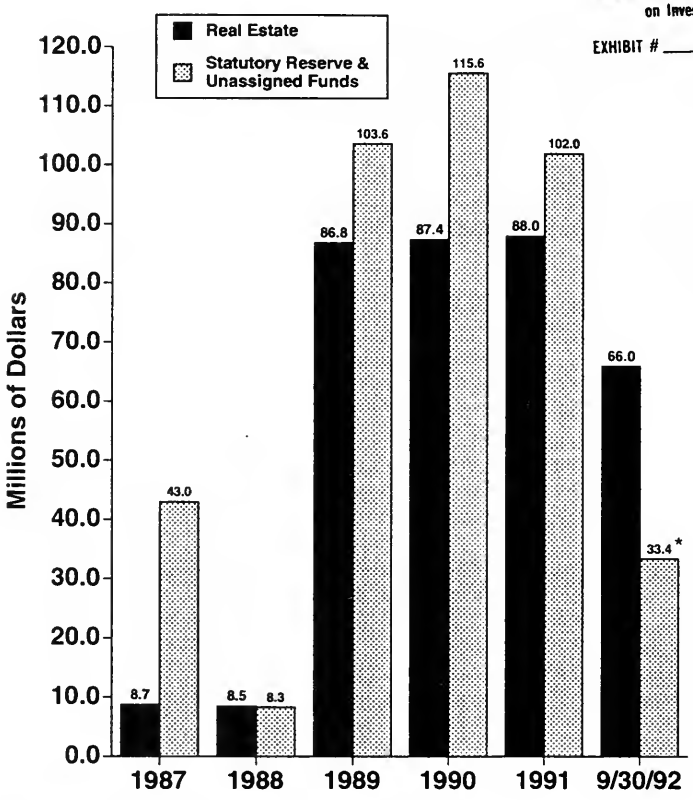
bj

enclosure

cc: Frank A. Gunther Jr., Board Chairman, Blue Cross and Blue Shield of Maryland
William A. Beasman Jr., Acting CEO, Blue Cross and Blue Shield of Maryland
Benjamin W. Giuliana, president, Blue Cross and Blue Shield of the National Capital Area

Relationship of Real Estate to Statutory Reserve and Unassigned Funds

Senate Permanent Subcommittee on Investigations
EXHIBIT # 17a.



* As adjusted by Va. Insurance Commission

BLUE CROSS AND BLUE SHIELD OF THE NATIONAL CAPITAL AREA

Minutes of the
Meeting of the Board of Trustees
Held in the Offices of BCBSNCA
Washington, D. C.
March 8, 1988

PRESENT

Trustees: Charlotte G. Chapman, Charles P. Duvall, M.D., Ralph W. Frey, Joseph P. Gamble, Ernest E. Harmon, M.D., Thomas R. Harrison, George W. Jones, M.D., Robert W. Langevin, M.D., Ira Laster, Jr., Ph.D., Peter D. LeNard, M.D., Anna B. J. Marsh, Matthew F. McNulty, Jr., Sc.D., Peter F. O'Malley, Lutrelle F. Parker, Benjamin S. Pecson, M.D., Robert E. Petersen, Charles L. Rickerich, M.D., George Speck, M.D., John E. Sumter, Jr., David S. Wiggin, Leo W. Zajac

Staff: V. M. Brian, B. W. Giuliani

Counsel: Charles J. Steele

ABSENT

Trustees: Mary Lou Barker, M.D., Robert C. Mayer, Victor E. Millar

Dr. Duvall, chairman, called the meeting to order at 6:45 p.m.

Mr. Giuliani, secretary, stated that the meeting had been duly called and that a quorum was present, whereupon the Chairman stated that it was in order to proceed with the business of the meeting.

Dr. Duvall welcomed George W. Jones, M.D. to the board of BCBSNCA. He noted that Dr. Jones had been a member of the board until January 1987.

MINUTES OF THE ANNUAL MEETING OF THE BOARD OF TRUSTEES - JANUARY 12, 1988

The Chairman stated that copies of the minutes of the annual meeting of the board of trustees of January 12, 1988 had been mailed to and noted by the trustees.

Dr. Duvall called upon Mr. Giuliani to identify a change which had been suggested to the January 12, 1988 minutes.

Mr. Giuliani stated that the change, which had been suggested by Mr. Zajac, was on page 8 in the first sentence of the second paragraph where Mr. Zajac

had suggested that the word "underwriting" be inserted between the words "the" and "losses". Mr. Giuliani also noted that several typographical changes had been made to the minutes.

It was then

VOTED: To approve the minutes of the January 12, 1988 annual meeting of the board of trustees as circulated and corrected.

REPORT ON SUBSIDIARIES

Mr. Gamble stated that copies of the "Report on Subsidiaries", dated March 8, 1988 had been mailed to the trustees with the tentative agenda material. He noted that the board had agreed at the January 12, 1988 meeting to receive reports on the subsidiaries at the March, July and November board meetings each year. He then presented a summary financial report and individual reports for each of BCBSNCA's major subsidiaries. He stated that these reports summarized the subsidiaries' 1987 activities and, in most cases, reflected financial data for 1986 through 1989.

Mr. Gamble stated that the amount of capital invested per subsidiary ranged from nominal amounts to $400,000. Mr. Gamble noted that a total of 22 subsidiaries have been established by BCBSNCA with an initial capital investment of only $3.5 million. He stated that this capital represented "seed" money, which was used to establish the subsidiaries. He noted that any additional funding required by a subsidiary was accomplished by the subsidiary borrowing funds based upon a line of credit guaranteed by BCBSNCA, or borrowing funds directly from BCBSNCA. He explained that the subsidiary is required to pay the interest on any such loans. He commented that the interest paid by the subsidiaries is a tax deductible expense. He explained that the subsidiaries have a choice of borrowing directly from BCBSNCA at the prime rate plus one percent, or borrowing through lines of credit arranged by BCBSNCA at rates slightly below the prime rate. Mr. Gamble noted that as of the end of 1987, a total of $18.4 million in lines of credit have been exercised by the subsidiaries. He also noted that of the total $18.4 million in outstanding debts, $10.8 million was borrowed by CapitalCare, Inc., and $7.6 million was borrowed by the remaining subsidiaries.

Mr. Gamble stated that, as authorized by the board at its meeting on January 13, 1987, BCBSNCA completed the acquisition of 304,206 shares, or 96.9%, of the stock of American Capital Life Insurance Company (ACLIC) on February 7, 1988, from its parent company, North Carolina Mutual Life Insurance Company. He stated that ACLIC is licensed to do business in five states and the District of Columbia, and that state licenses are worth between $75,000 and $100,000 each. He said that the purchase price of ACLIC was $1.5 million, as had been authorized by the board. He noted that

an annual meeting of the shareholders of ACLIC was held on February 24, 1988, at which time new directors were elected to serve. Mr. Gamble also noted that an organizational meeting of ACLIC was held following the shareholders meeting. He said that while a formal 1988 financial or strategic plan has not yet been developed, it is anticipated that ACLIC will allow BCBSNCA to offer and underwrite group life and accidental death and disability products, as well as individual life and accidental death and disability products and long-term health products through flexible benefits programs to BCBSNCA's group accounts. He stated that as of December 31, 1987, paid-in capital and surplus of ACLIC was $771,456, with $36 million of ordinary non-participating business in force. Mr. Gamble noted that during 1987, ACLIC had premium income of $493,229, and added $47,464 to its capital and surplus. He stated that BCBSNCA would, in the future, begin to move life insurance sold by BCBSNCA from other life carriers to ACLIC. He said that once financial data has been projected, it will be reported to the board, along with data for the other subsidiaries.

Mr. Gamble stated that for the information of the board, three of BCBSNCA's subsidiaries have created subsidiaries for their own purposes, as follows:

- National Capital Administrative Services, Inc., (NCAS), BCBSNCA's third-party administrator (TPA) subsidiary, incorporated NCAS Insurance Agency, Inc. on December 8, 1987. This company was organized in order for NCAS to conduct and operate a general insurance agency and/or brokerage business, and to contract with and act as general brokers for authorized insurance companies offering life, health, accident and sickness, disability and other types of insurance in making such insurance available to NCAS clients. The amount of capitalization was $1,000.

- The board of directors of Emtrust, Inc., a joint venture with INOVA Health Systems, Inc. and its hospitals in Fairfax County, Virginia, authorized the creation of Emtrust Reinsurance Company, Inc. on January 27, 1988. This company, which was granted a certificate of incorporation in the District of Columbia on January 29, 1988, will be formed to meet the need for readily available stop-loss insurance for both specific and aggregate stop-loss insurance for Emtrust accounts. The amount of capitalization will be $600,000, which will be fully funded by an Emtrust line of credit.

- On February 9, 1988, the board of directors of International Health Benefits, Inc., a subsidiary formed to manage such activities as our United States Virgin Islands operation, created International Health Benefits of Panama, Inc. to act as a service company and a general agency for International Health Benefits, Inc.'s activities in Panama. The amount of capitalization was $2,500.

Also, on February 10, 1988, the organizational meeting of a corporation named World Access Canada, Inc. was held. World Access, Inc. has a 50% interest in that company.

Mr. Gamble then presented a summary of financial data on BCBSNCA subsidiaries as of December 31, 1987 as follows:

	1986 Actual	1987 Actual	1988 Forecast	1989 Forecast
Revenue	$14,364,208	$43,531,139	$76,315,836	$116,356,483
Operating Expense	$24,722,683	$51,364,847	$78,955,928	$111,882,144
Net Gain (Loss) from Operations	($10,358,475)	($7,833,708)	($2,640,092)	$4,474,339
Other Income and (Expense)	($427,193)	($1,052,364)	($1,447,402)	($1,304,374)
Net Gain (Loss)	($10,785,668)	($8,886,072)	($4,087,494)	$3,169,965

Mr. Gamble stated that the data, presented in summary form, does not compare to the financial data reflected on the consolidated financial statements, which will be reported under the "Auditor's Report" later in the meeting. He stated that the consolidated financial statements include those subsidiaries which BCBSNCA owns 51% or more of the stock, whereas the data presented in the "Report on Subsidiaries" reflects a broad overview of subsidiaries which have significant revenue and expense, including those which BCBSNCA owns less than 51%. Mr. Gamble stated that the summary data by year reflects substantial increases in revenue, along with a decline in net losses, comparing 1986 actual to 1987 actual, and continuing declines in losses under the 1988 forecast and then turning into a net gain forecasted for 1989.

Access America, Inc.

Mr. Gamble reported that Access America, Inc. continues to establish itself as one of the leading travel insurance and assistance companies in the industry. He stated that Access America has experienced rapid growth in its sales activities and revenues during the past year.

Mr. Gamble stated that Access America is segmented into retail business, group and very large group components. He noted that in the retail section, it has approximately 9,000 travel agency distributors, and has made significant penetration of the tour operator market. He said that also, its private labeling program has proven very successful. He stated that it currently is a final bidder for a national MasterCard account.

Mr. Gamble stated that Access America has continued to make excellent use of public relations. He said its representatives continue to appear on radio and local television programs, discussing the benefits of travel insurance and relating to viewers the potential medical, legal and travel problems that can occur when one is traveling. He noted that while many people mistakenly believe Access America does extensive advertising, it has been its ability to work with travel writers that allow it to appear almost weekly in newspapers across the United States.

Mr. Gamble summarized the financial data for Access America, Inc. as of December 31, 1987:

	1986 Actual	1987 Actual	1988 Forecast	1989 Forecast
Revenue	$2,694,024	$9,606,894	$12,858,086	$16,775,252
*Operating Costs	$5,772,424	$9,998,557	$12,757,615	$16,127,400
Net Gain (Loss) from Operations	($3,078,400)	($391,663)	$100,471	$647,852
Other Income and (Expense)	($110,976)	($219,266)	($193,352)	($200,000)
Net Gain (Loss)	($3,189,376)	($610,929)	($92,881)	$447,852

*Includes: Insurance Premiums to BCS Financial
Service Fees to World Access
Commissions to Travel Agencies
Administrative Expenses

CapitalCare, Inc.

Mr. Gamble reported that enrollment in CapitalCare, Inc. as of the end of 1986 totaled 9,000 members, and has increased as of January 31, 1988 to 51,019 members. He noted that comparing this result to projections, the actual number of members in force exceeded the number of members budgeted by 5,800 members, or 12.9%. He also noted that total membership in CapitalCare is expected to be approximately 67,000 at year-end.

Mr. Gamble stated that in September 1987, CapitalCare relocated its offices from Crystal City to Tysons Corner, Virginia. He said that as a result, CapitalCare occupies two full floors of space which, with options on additional space, should be sufficient to meet its needs over the next three to five years.

Mr. Gamble stated that in 1987, CapitalCare, in conjunction with BCBSNCA, put together the administrative and other support structures needed to allow CapitalCare to provide services outside the federally qualified health maintenance organization (HMO) setting. He said that as a result, CapitalCare is now positioned to offer an experience-rated HMO program, as well as to provide the HMO complement in dual-option, integrated price sales efforts. He noted that as of January 1988, 20 employer groups, including Giant Food, had selected the dual-option offering. Mr. Gamble stated that CapitalCare enrollment in those offerings totaled 2,567 members.

1987 Financial Results

Mr. Gamble stated that because of stiff price competition, newly formed HMO's must price their product as if they were a more mature organization, and, therefore, CapitalCare, when it had only 9,000 members, set prices as if it had 70,000 to 80,000 members.

Mr. Gamble reported that a certified audit of CapitalCare's operations had been completed by Price Waterhouse for the year ended December 31, 1987. He stated that the balance sheet showed accumulated deficits of $10.9 million, compared to $6.5 million at the end of 1986. He said that the increase in the deficit reflected a net operating loss of $4.4 million for 1987, which was generally in line with the loss that had been projected, though somewhat higher, primarily as a result of increased benefit costs, as well as some one-time charges associated with the relocation of the company's offices. He noted that CapitalCare is expecting to have its first net gain in 1989.

Mr. Gamble summarized the financial data for CapitalCare, Inc. as of December 31, 1987:

	1986 Actual	1987 Actual	1988 Forecast	1989 Forecast
Revenue	$5,587,260	$23,551,691	$47,908,000	$77,094,000
Operating Expense	$9,047,507	$27,513,724	$50,280,000	$76,349,000
Net Gain (Loss) from Operations	($3,460,247)	($3,962,033)	($2,372,000)	$745,000
Other Income and (Expense)	($296,687)	($432,150)	($723,000)	($693,000)
Net Gain (Loss)	($3,756,934)	($4,394,183)	($3,095,000)	$52,000

Dr. Pecson stated that there have been concerns about CapitalCare among physicians. Dr. Speck then commented that he has expressed that sentiment

to the board in the past. Dr. Harmon commented that based upon a request he had received from another physician regarding CapitalCare, he had talked to Mr. David Metz, President of CapitalCare, Inc. He said that Mr. Metz stated that there was no reason why a member of the BCBSNCA board should have to call him regarding a matter pertaining to CapitalCare. Dr. Harmon stated that when a member of the board is requested to resolve a problem, it is natural, in his view, to contact the president of CapitalCare. He noted that while the issue worked out well, he was shocked by the attitude reflected by Mr. Metz. Mr. Gamble stated that he would not attempt to defend Mr. Metz, but he noted that Mr. Metz is a very capable HMO administrator. He also noted that Mr. Metz started CapitalCare, and has done quite well in increasing CapitalCare's membership, but that he would talk to Mr. Metz regarding his attitude. Mr. Petersen stated that Mr. Gamble had indicated that he would deal with Mr. Metz on these matters, but that he assumes the board members are not expressing any problem with CapitalCare's programs. He indicated that he personally has not had any difficulties in his dealings with Mr. Metz.

Dr. LeNard asked whether or not there were any current activities underway between CapitalCare and the Fairfax Hospital Association (FHA). Mr. Gamble responded that at this time there were no activities underway. He stated that a contract does not exist between the two organizations, but that FHA has recently agreed to contract with an organization that ceased to contract with Alexandria Hospital and Arlington Hospital. Mr. Gamble also noted that Emtrust, Inc., BCBSNCA's joint venture with FHA, wants to sell CapitalCare's benefit program, and, therefore, is pressuring FHA to contract with CapitalCare. He said that to the best his knowledge, FHA has not decided how to respond to Emtrust's request. Mr. Gamble noted that, in addition, there is presently a great deal of activity underway in Fairfax County. He stated that he has learned that the Physician Health Plan, a competitor of CapitalCare and which FHA or its parent has invested 10%, has again requested additional funds, and FHA seems to be backing off of that commitment.

Emtrust, Inc.

Mr. Gamble reported that Emtrust, Inc., the joint venture of BCBSNCA and INOVA Health Systems, Inc., is the organization that integrates the services of National Capital Administrative Services, Inc. with INOVA's hospital system to provide small- to medium-sized employers with the benefits of self-funding and provider discounts.

Mr. Gamble stated that Emtrust ended 1987 administering the benefits for 1,539 employees in Northern Virginia, and forecasts that 6,000 employees will carry an Emtrust card by the end of 1988. He noted that currently, Emtrust is concentrating its efforts in Northern Virginia, but is planning on expanding to the full Washington metropolitan area during 1988.

Mr. Gamble stated that major projects for 1988 include the formation of Emtrust Reinsurance Company, Inc. which will accommodate the risk-sharing agreement between BCBSNCA and INOVA, plus the development of further provider discounts. He said that currently, Emtrust is negotiating with Internet Corporation on hospital discounts at seven more area facilities, and with CapitalCare for a dual-option product.

Mr. Gamble summarized the financial data for Emtrust, Inc. as of December 31, 1987:

	1986 Actual	1987 Actual	1988 Forecast	1989 Forecast
Revenue	0	$36,723	$315,000	$638,500
Operating Expense	0	$295,224	$614,930	$824,675
Net Gain (Loss) from Operations	0	($258,501)	($299,930)	($186,175)
Other Income and (Expense)	0	$5,038	$3,250	$18,250
Net Gain (Loss)	0	($253,463)	($296,680)	($167,925)

Health Management Strategies International, Inc.

Mr. Gamble reported that for 1987, Health Management Strategies International, Inc.'s (HMS's) primary goal was to increase its revenue to over $4 million by (1) implementing the Managed Care Program for the majority of BCBSNCA accounts; and (2) selling business to accounts unaffiliated with BCBSNCA.

Mr. Gamble noted that the objective of implementing the Managed Care Program for the majority of BCBSNCA accounts is near completion. He said that HMS has added the majority of the experience-rated business to Managed Care. He stated that groups with Preadmission Certification and Second Surgical Opinion programs are converting to Managed Care as they renew their health care coverage. Mr. Gamble stated that each month since March 1987, a portion of the community-rated group business has started with HMS. He noted that as of December 31, 1987, approximately 50,000 community-rated group contracts have added Managed Care, with the remaining 15,000 contracts scheduled to be added by February 1, 1988. Mr. Gamble said that the BCBSNCA direct-billed business began Managed Care on August 1, 1987. He stated that total 1987 Managed Care revenue from BCBSNCA-affiliated business was $1,400,000.

Dr. Laster stated that he has recently seen articles regarding early discharge of patients from hospitals. He stated that he was interested to

learn whether or not HMS has an arrangement in which they can obtain patient feedback regarding early discharges. It was noted that none of the staff members present were aware of any such arrangement by HMS. Dr. Duvall noted that a patient's views are based on a case by case situation, and in some instances the patient may be very disturbed about a situation such as this. Dr. Duvall identified one particular case concerning a Medicare patient in which he was involved. He also noted that the doctor is legally responsible for the care of the patient, and he stated that, fortunately, there are not many cases where the issue of early discharge arises.

Mr. Gamble stated that the real issue is the need for care, and that the care should be rendered regardless of a carrier's decision. Mr. Steele noted that many legal cases pertaining to managed care programs are presently waiting to be heard.

Mr. Gamble explained that the Blue Cross and Blue Shield Association (BCBSA) Director's Office continues to contract with HMS for services to subscribers enrolled with the Federal Employee Program (FEP). He noted that the three-year Psychiatric Pilot Program was completed in 1987. He said that the 1987 revenue from this pilot program was $280,000. Mr. Gamble said that for 1988, HMS will be providing Individual Benefits Management services to FEP subscribers for projected revenues of $130,000. He said that the 1987 FEP Hospital Bill Audit activity totaled $60,000 in revenue. Mr. Gamble noted, however, a downward adjustment to the 1986 Psychiatric Pilot Program revenue and a reduction in the allowable costs for the 1986 Hospital Bill Audit Program reduced 1987 FEP revenue. He stated that, as a result, 1987 total revenue from FEP business, after the 1986 adjustments, was approximately $187,000.

Mr. Gamble stated that HMS' Bell Atlantic experience has been a success. He noted that on January 1, 1987, the approximately 50,000 non-management employees were covered by Preadmission Certification and Second Surgical Opinion programs. He stated that these subscribers were added to HMS' system while management employees were kept on the Health Data Institute's (HDI's) software system. He said that as a result of non-management's experience on the HMS system, the management employees were converted from HDI's to HMS' system on July 1, 1987, and HMS discontinued the software licensing agreement with HDI on that date. Mr. Gamble stated that total 1987 Managed Care revenue from Bell Atlantic was $900,000.

Mr. Gamble stated that another significant aspect of the Bell Atlantic business is that HMS and the Bell Atlantic Implementation Department of BCBSNCA have jointly developed utilization and benefit reports that have replaced the HDI reports. He noted that these reports will become a standard feature of the Bell Atlantic business when the entire account is serviced by the FLEXX system.

Mr. Gamble stated that HMS' account reporting activity produced $475,000 in revenue during 1987; the Hospital Services Review Program generated $268,000 in revenue, and the Health Risk Management service produced $160,000 in revenue.

Mr. Gamble stated that total revenue produced by HMS in 1987 was approximately $3,600,000. He noted that after the prior year adjustments, HMS ended the year with $3,400,000 in revenue. He said that although this fell short of the $4 million goal, this figure represents a 73% increase over 1986 revenue.

Mr. Gamble stated that as a result of the revenue shortfall, HMS had a net loss of approximately $600,000 in 1987. He said that this was primarily due to an inability to sell Managed Care to accounts unaffiliated with BCBSNCA.

Mr. Gamble explained that to ensure profitability in 1988, HMS has taken the following actions:

1. Redirected its marketing efforts to concentrate on Managed Care sales to accounts unaffiliated with BCBSNCA to produce approximately $600,000 in new revenue during 1988.

2. Reduced the 1988 operating budget by over $700,000 by downsizing the corporate staff, reducing merit increases by 3% and cutting salary expenses.

Mr. Gamble stated that in summary, HMS has nearly achieved the goal of implementing the Managed Care Program for the majority of BCBSNCA accounts. He said that although HMS was unprofitable in 1987, significant executive actions were taken to ensure profitability in 1988.

Mr. Gamble noted that attachment A reflected information relating to HMS' recently implemented Individual Benefits Management services activity from May 4 through December 31, 1987 as follows:

Closed Cases	Year-to-Date Savings
Case A	$ 6,147.46
Case B	3,420.30
Case C	21,925.13
Case D	8,276.00
	$39,768.89

Open Cases	Year-to-Date Savings	Total Expected Savings
Case E	$ 4,800.00	$ 12,000.00
Case F	24,780.00	49,560.00
Case G	10,912.20	65,473.20
Case H	144,616.80	439,876.10
	$185,109.00	$566,909.30

Mr. Gamble summarized the financial data for Health Management Strategies International, Inc. as of December 31, 1987:

	1986 Actual	1987 Actual	1988 Forecast	1989 Forecast
Revenue	$1,999,468	$3,458,204	$5,616,780	$7,873,716
Operating Expense	$2,623,560	$3,985,059	$5,135,515	$6,015,220
Net Gain (Loss) from Operations	($624,092)	($526,855)	$481,265	$1,858,496
Other Income and (Expense)	$35,748	($71,399)	($142,800)	($135,300)
Net Gain (Loss)	($588,343)	($598,254)	$338,465	$1,723,196

Mr. Gamble stated that the forecasted gain for 1988 may be high due to recent cuts made in HMS' costs, and, therefore, the actual 1988 results may deviate from the forecast.

National Capital Administrative Services, Inc.

Licensing

Mr. Gamble reported that the network of third-party administrator (TPA) distributorships licensing the National Capital Administrative Services, Inc. (NCAS) system includes subsidiaries of the Arizona, Michigan, Washington/Alaska, West Virginia and Wyoming Plans. He said that the Rochester, New York and Harrisburg, Pennsylvania Plans are very seriously considering becoming licensees. He stated that other Plans recently expressing an interest in the NCAS claims processing system are located in

Colorado, Maine, Montana, New Hampshire, New Mexico, Nevada, North Dakota, Rhode Island and Vermont. Mr. Gamble stated that the network has developed a users group for mutual support on technical projects, and licensees routinely share sales proposal materials and other marketing concepts. He said that the Seattle TPA now administers 15,000 insureds and is aggressively marketing to other large accounts. He noted that the trend is toward standardization -- in terms of work procedures, external materials and name identity. Mr. Gamble commented that NCAS is the most common name for these companies. He stated that for every insured administered by an NCAS affiliate, NCAS receives 60 cents per month and NCAS then has to reimburse the licensor only 41½ cents per month.

Local Business

Mr. Gamble stated that during 1987, NCAS acquired groups from CIGNA; Prudential; Willse & Associates, the Maryland Plan's TPA; Group Administrative Services, a Baltimore TPA owned by CIGNA; Group Insurance Administration, a Chicago TPA; Trust Fund Administrators, a local Maryland TPA; and Blue Cross and Blue Shield of Maryland, Inc. He said that to date, NCAS has not lost a group, and approximately 15,000 insureds have been enrolled within the past six months.

Mr. Gamble stated that the largest new accounts for NCAS include Dominion Federal, Maxima, and the Agency for International Development, all effective January 1, 1988. He commented that large local accounts, such as Potomac Electric Power Company and Washington Gas Light Company, use TPA's to administer their programs. He said, therefore, that it is not possible for BCBSNCA to enroll such accounts, but that NCAS could have more success at this.

Mr. Gamble noted that due to rapid growth of NCAS business, plans have been developed to expand its existing office space to accommodate this and future growth.

Future

Mr. Gamble also reported that NCAS staff predicts that Flexible Benefit Plan Administration will be the fastest growing line of business for NCAS in 1988. He stated that NCAS is prepared to expand its capabilities to also include union business. He said that a Taft-Hartley coordinator was employed on September 1, 1987 to help develop this line of business. He noted that until business is sold, no further investment is contemplated.

Mr. Gamble stated that the NCAS system has been enhanced to support the new Flexible Spending Account line of business and there are already four groups scheduled for implementation during the first quarter of 1988.

Mr. Gamble summarized the financial data for National Capital Administrative Services, Inc. as of December 31, 1987:

	1986 Actual	1987 Actual	1988 Forecast	1989 Forecast
Revenue	$1,130,968	$2,336,248	$3,845,244	$6,543,826
Operating Expense	$2,654,752	$4,113,293	$4,720,644	$6,247,635
Net Gain (Loss) from Operations	($1,523,784)	($1,777,044)	($875,400)	$296,191
Other Income and (Expense)	($22,071)	($69,254)	($108,150)	($73,838)
Net Gain (Loss)	($1,545,855)	($1,846,298)	($983,550)	$222,353

Mr. Gamble noted that NCAS is writing-off the cost of its system at the rate of $41,000 per month through late 1989, and stated that without that expense, NCAS would only lose $500,000 in 1988, and would make nearly $750,000 in 1989.

National Capital Insurance Agency, Inc.

Mr. Gamble reported that National Capital Insurance Agency, Inc. (NCIA) has enjoyed continued growth in its group business. He stated that by the close of 1985 and 1986, monthly commissions and fees earned by the agency averaged $32,374 and $35,653, respectively. Mr. Gamble said that in 1987, monthly commissions and fees averaged $42,416, an increase of approximately 19%. He stated that a focus on the marketing of long-term disability products, opening up the 2-9 member group business to broker sales, and increased collection activities have contributed to this growth. He noted that enrolled accounts have increased to 2,700, and administrative management of enrollment, billing and commissions has been facilitated by the complete installation of the Regional Marketing, Inc. billing system.

Mr. Gamble stated that expansion of the agency's marketing lines now includes individual life and disability products, direct-mail, business insurance, and group payroll deduction products. He said that the initial direct-mail offering is expected to be made in March 1988, with a second mailing to take place in September 1988. Mr. Gamble said that the structure for offering payroll deduction universal life through brokers and on a direct basis has been established, and several prospects are currently being pursued. He stated that two accounts with 300 members and 600 members, respectively, have enrolled for universal life payroll deduction programs to take place in March 1988. He noted that marketing efforts for the universal life programs have been coordinated with Custom Benefit

Services' Flexible Spending Account. Mr. Gamble stated that this combination has received a favorable reception with many of the brokers and consultants to whom it has been presented.

Mr. Gamble stated that profit sharing for NCIA on the block of group business has been extremely limited during the last two years. He said that unusually high claims activity occurred during 1985 with NCIA's primary carrier, American Bankers Life (ABL). He noted that gains during 1986 were inadequate to overcome the prior year's deficit with ABL. Mr. Gamble said that preliminary figures from ABL do not indicate any profit-sharing distribution for 1987. He said that Companion Life, however, has reported unofficially, that profit-sharing proceeds available for 1987 for NCIA are expected to be approximately $50,000.

Mr. Gamble noted that with the increased growth of business, expansion of the small group market and increased collection activities, profit sharing is expected to improve in 1988, with proceeds to be received in 1989. He stated that income from individual lines of coverage, direct-mail activity, expanded group business and profit sharing with its carriers is expected to place the agency in a positive financial operating position during 1989.

Mr. Gamble summarized the financial data for National Capital Insurance Agency, Inc. as of December 31, 1987:

	1986 Actual	1987 Actual	1988 Forecast	1989 Forecast
Revenue	$534,507	$508,994	$890,250	$1,087,605
Operating Expense	$854,247	$739,981	$893,990	$971,852
Net Gain (Loss) from Operations	($319,740)	($230,987)	($3,740)	$115,753
Other Income and (Expense)	$49,712	($20,792)	($68,000)	($68,000)
Net Gain (Loss)	($270,029)	($251,778)	($71,740)	$47,753

Professional Office Systems, Inc.

Mr. Gamble reported that during the past year, Professional Office Systems, Inc. (POSI) has been engaged in three major activities.

Mr. Gamble stated that the first of these is the marketing of a productivity manager software package which aids companies with a high volume of clerical activities in improving productivity. He said that the product is installed in banks, retail stores, and insurance companies. He

said that, in addition, POSI currently has a national agreement with a work management company to install the product in a large number of its clients' offices.

Mr. Gamble stated that a second major activity is providing automation to providers of health care. He said that this is accomplished by providing small personal computers in physician, hospital and dentist offices which allow for billing and claims activity. He said that this activity currently has over 30 installations providing automation to the provider community.

Mr. Gamble stated that the third activity is to provide electronic claims submission from provider billing locations to BCBSNCA. He said that this process will result in a high volume of claims becoming "touchless". He explained that it will allow for claims to come from the provider to BCBSNCA, and for payments to be generated to the provider or subscriber without manual intervention at BCBSNCA. Mr. Gamble stated that an effort is underway to provide all participating providers, regardless of the type of automation they have, with this capability. He said that BCBSNCA received 525,000 claims through some form of electronic media during 1987. He said that POSI hopes to increase that number to 850,000 claims in 1988, thereby reducing BCBSNCA's administrative costs.

Mr. Gamble stated that POSI is continually looking at new products which will benefit BCBSNCA and the provider community. He said that while not all activities are necessarily profitable, they are all dedicated to improving customer service and reducing administrative costs at BCBSNCA.

Mr. Gamble summarized the financial data for Professional Office Systems, Inc. as of December 31, 1987:

	1986 Actual	1987 Actual	1988 Forecast	1989 Forecast
Revenue	$1,272,940	$1,325,903	$1,651,680	$2,119,824
Operating Expense	$1,628,787	$1,794,067	$1,819,412	$2,089,294
Net Gain (Loss) from Operations	($355,848)	($468,164)	($167,732)	$30,530
Other Income and (Expense)	$38,195	($63,189)	($98,554)	($117,488)
Net Gain (Loss)	($317,652)	($531,353)	($266,286)	($86,958)

Protocol

Mr. Gamble reported that Protocol became a wholly owned subsidiary of Blue Cross and Blue Shield of the National Capital Area on February 16, 1988 with the formal withdrawal of Medlantic Healthcare Group from the partnership. He said that the major points of the agreement include:

- Medlantic relinquished all rights to its initial $100,000 capital contribution.
- Medlantic relinquished the rights to the trademark: Protocol, The International Source For Healthcare.
- Medlantic has a 50% contingent liability on the initial $998,000 line of credit. This contingent liability is reduced over the next five years at the rate of 1/60 per month.
- Ownership of the provider network has been assigned and transferred to Protocol.
- Protocol is now responsible for credentialing and contracting with providers, as well as overseeing the peer review function.
- Protocol will establish a three-member credentialing committee, comprised of Jack Kleh, M.D., Protocol's Medical Advisor, a member of Protocol's staff, and a Medlantic appointee (Medlantic has right to appoint one member for a period of five years).
- Medlantic Healthcare Group has the right to appoint one director to the Protocol board of directors for a period of five years.
- Medlantic Healthcare Group will provide Protocol with a 5% discount in addition to BCBSNCA's discount on its regular business for five years at all of Medlantic's member facilities.
- Georgetown University Hospital will be added to the network as soon as the hospital agrees, bringing the total of Protocol network hospitals to eleven. Protocol, for a period of five years, will contract only with the following hospitals:

Reston Hospital Center	Children's Hospital
Arlington Hospital	Capitol Hill Hospital
Montgomery General Hospital	Columbia Hospital for Women
Suburban Hospital	Washington Hospital Center
Holy Cross Hospital	Georgetown University Hospital
Shady Grove Adventist Hospital	

(NOTE: Protocol will offer a contract to any additional facilities which become affiliated with Medlantic.)

- Protocol is free to contract with any hospital, physician or healthcare provider outside of BCBSNCA's existing service area.

Mr. Gamble stated that Protocol staff has been actively engaged in refining and restructuring the customer service element of the product. He said that major elements in this restructuring included National Capital Administrative Services, Inc. (Protocol's claims and billing processor), establishing a dedicated team to exclusively pay Protocol claims and answer client claim and benefit inquiries, and the assumption by Protocol beginning April 1, 1988 of the premium billing functions.

Mr. Gamble noted that Protocol now insures approximately 60 diplomatic and international organizations, representing $2.5 million of revenue to BCBSNCA and $250,000 of annual revenue to Protocol. He stated that, more importantly, Protocol's monthly net revenue and enrollment has increased by 60% over the past 90 days (monthly net revenue of $19,200 and enrollment of 4,750 members). Mr. Gamble said that some of the more noteworthy clients enrolled by Protocol recently include the Embassies of Switzerland, Mexico, Spain, Ireland, Surinam, Panama and the Saudi Arabian Educational, Medical and Commercial Offices.

Mr. Gamble stated that another by-product of Protocol's recent success is the creation of other business opportunities, either for Protocol or the International Division of BCBSNCA in other countries. He said that discussions are now under way with appropriate international marketing personnel to determine the best course of action. He also stated that Protocol is considering expanding into New York City to address the United Nations market, as well as San Francisco, California where many countries have diplomatic missions.

Mr. Gamble summarized the financial data for Protocol as of December 31, 1987, and noted that a revised forecast is being prepared as a result of Protocol becoming a wholly owned subsidiary of BCBSNCA:

	1986 Actual	1987 Actual	1988 Forecast	1989 Forecast
Revenue	$2,820	$54,995		
Operating Expense	$338,002	$440,365		
Net Gain (Loss) from Operations	($335,182)	($385,370)		
Other Income and (Expense)	$1,641	$2,980		
Net Gain (Loss)	($333,541)	($382,390)		

World Access, Inc.

Mr. Gamble reported that World Access, Inc. (WAI) has continued its efforts to assist in the expansion of the Blue Cross and Blue Shield international hospital network. He stated that World Access has negotiated contracts with the Kupat Holim and Hadassah Hospital systems of Israel. He noted that additional hospital contracts in Japan, West Africa and Europe have also been brought to fruition or are in final negotiations.

Mr. Gamble stated that major target areas for network expansion in 1988 include West Germany and the Pacific Rim countries.

He stated that World Access has recently developed joint ventures in Canada and Australia. Mr. Gamble noted that the Canadian company, World Access Canada, Inc., is already marketing and selling an assistance product to major commercial insurance companies in Canada. He stated that in Australia, World Access is in the final stages of negotiating with Travel Power, an Australian-based travel company for the creation of an Australian assistance company of which WAI would own 40%. He said that both of these programs have a great deal of promise.

Mr. Gamble also stated that WAI is performing services for Protocol and CapitalCare.

He then summarized the financial data for World Access, Inc. as of December 31, 1987:

	1986 Actual	1987 Actual	1988 Forecast	1989 Forecast
Revenue	$1,142,221	$2,651,487	$3,230,796	$4,223,760
Operating Expense	$1,803,404	$2,484,577	$2,733,822	$3,257,068
Net Gain (Loss) from Operations	($661,183)	$166,910	$496,974	$966,692
Other Income and (Expense)	($122,755)	($184,332)	($116,796)	($34,998)
Net Gain (Loss)	($783,938)	($17,423)	$380,178	$931,694

In concluding the report, Mr. Gamble stated that he believes the subsidiaries to be crucial, and possibly a survival issue with respect to BCBSNCA.

Mr. O'Malley asked if the five-year projection for each of these subsidiaries could be provided to the board at the May 8, 1988 meeting. Mr. Gamble stated that the next report on subsidiaries is scheduled for the

July 12, 1988 board meeting, at which time he would be happy to present to the trustees the five-year projection for each subsidiary. Mr. O'Malley asked that the report reflect prior-year projections, compared to actual results for such years. Mr. O'Malley also asked whether thought had been given to closing any of BCBSNCA's subsidiaries. Mr. Gamble responded that at this time, no thought has been given to closing any subsidiary because each subsidiary is growing.

Dr. Speck commented that he did not wish to be negative, but noted that in a recent newspaper article, the Virginia Insurance Department expressed concerns regarding BCBSNCA's subsidiaries and reserve levels. He stated that based upon projections presented in this report, the subsidiaries may be in the black in 1989, but noted that it may take five or more years to recoup the losses. Dr. Speck noted that Blue Cross and Blue Shield organizations started out as health insurance organizations. He stated that since the board has been informed about expansion into areas which he feels are not expanding the core business, he is concerned with BCBSNCA's future. Mr. Gamble stated that BCBSNCA has invested a total of $3.5 million in its subsidiaries, and, as he previously stated, he believes that these subsidiaries are a survival issue. He stated that there has been a gradual deterioration of Blue Cross and Blue Shield enrollment, and that these subsidiaries are needed in order for BCBSNCA to survive in the future. Dr. Speck commented that BCBSNCA may not survive. Mr. Gamble responded that these subsidiaries will permit BCBSNCA to survive.

A discussion then followed regarding the $18.4 million line of credit which has been exercised by the subsidiaries and which is guaranteed by BCBSNCA.

Dr. Harmon then stated that the initial capital investment by BCBSNCA has totaled $3.5 million. He said that with CapitalCare's outstanding line of credit of $10.8 million, and $7.6 million in outstanding lines of credit for all other subsidiaries, BCBSNCA has a total potential investment of $21.9 million in subsidiaries.

Dr. McNulty stated that relative to the five-year projection to be included in the "Report on Subsidiaries" at the July 1988 meeting, he felt that the report should reflect the actual outstanding lines of credit for each subsidiary, and the projection of such loan balances in five years. He expressed that this information would help the board to see the projected reduction in the total outstanding commitment of nearly $22 million for BCBSNCA's subsidiaries.

Dr. Laster asked whether or not other Plans are diversifying. Mr. Gamble replied that a majority of Plans are going in the same direction as BCBSNCA. He stated, however, that they are not involved in such activities as World Access, Inc., but are involved in third-party administrators (TPA's), health maintenance organizations (HMO's) and managed care programs. He stated Plans have found that by establishing subsidiaries, they are able to prevent business from going to their competitors. Dr. Speck noted it appeared that other Plans are expanding in

areas of health insurance, but that BCBSNCA has gone beyond that. Mr. Gamble stated that Blue Cross of Western Pennsylvania (BCWP) has established a real estate subsidiary, which owns a city block in downtown Pittsburgh. In addition, BCWP has a TPA and they are working with Blue Cross and Blue Shield of Utah. He again emphasized the point that Blue Cross and Blue Shield Plans are diversifying.

Mr. Zajac noted the "Report on Subsidiaries" reflected that most of the subsidiaries are related to areas of health care and those that are not, deal with life insurance programs, which support the health care business. Mr. Wiggin commented that being an individual with a financial background, he is fairly conservative. He stated that most newly established organizations take three to four years to return a profit. He stated that this report reflects in four years the subsidiaries in total will begin to return a profit to BCBSNCA. He noted that a review of operational results reflected rapidly increasing revenues with declining losses. Mr. Wiggin said that this report reflected reasonable performance for new ventures. He stated that BCBSNCA's subsidiaries have been capitalized on a very conservative basis, and, instead of investing large capital amounts, the subsidiaries have been required to borrow funds. He said that in the future, in a collective sense, these subsidiaries should be supporting BCBSNCA quite well.

It was then

VOTED: To accept the Report on Subsidiaries dated March 8, 1988.

MINUTES OF THE MEETING OF THE LONG-RANGE PLANNING COMMITTEE - JANUARY 14, 1988

The Chairman stated that copies of the minutes of the meeting of the Long-Range Planning Committee of January 14, 1988 had been mailed to and noted by the Committee members. He said the minutes were included with the tentative agenda material for the remaining trustees.

Mr. Frey, chairman of the Committee, stated that the Committee initially reviewed a report presented by BCBSNCA staff pertaining to the three-year cycle of gains and losses. He noted that with BCBSNCA's rapidly declining reserves, presently under $100 million, that this information would help the Committee better understand the cyclical nature of the business. He stated that Mr. Gamble then presented a report similar to the "Report on Subsidiaries", which had previously been discussed by the board during this meeting. Mr. Frey stated that the discussions by the board of trustees regarding the "Report on Subsidiaries" were quite similar to the those held by members of the Long-Range Planning Committee. He said that the Committee reviewed the profits which were projected, and it was noted that several subsidiaries are presently at a break-even point, and would become

profitable during 1988. He stated that as a result of these discussions, the Committee voted to recommend that the board adopt the following corporate policy on diversification:

> "That it be BCBSNCA's policy to encourage expansion and diversification, both locally and internationally, in those businesses that are incidental to or supportive of the business and affairs of this Corporation or its subsidiaries and affiliates so as to minimize the negative effect on the Corporation during business cycles when underwriting losses can be expected to occur."

Mr. Frey then moved that the board adopt the recommendation of the Long-Range Planning Committee.

Mr. Parker noted that the recommendation did not refer to the purpose of BCBSNCA. He then referred to the ongoing activities of the Virginia Assembly, which has resulted in BCBSNCA being scrutinized. Therefore, he felt that any future activities should have a definite relation to BCBSNCA's purpose. He noted that a hospital equipment company is suing several non-profit hospitals for creating a venture in competition with the company. Therefore, Mr. Parker thought that it would be helpful if the diversification undertaken by BCBSNCA was on record and related to its purpose.

Mr. Parker recommended that the corporate policy on diversification be amended by inserting the word "purpose," before "business and affairs". It was then agreed to accept this recommended change.

Dr. Speck stated that given the degree of unrest with governments around the world, he could not accept the word "internationally" as part of the recommended corporate policy on diversification. He said that he preferred to use the term "locally" or "within the United States", and, therefore, he moved to delete the word "internationally" from the policy.

Dr. LeNard commented that Washington, D. C., as the nation's capital, is becoming an international community. Therefore, he said that he believed it appropriate for BCBSNCA to be involved in international activities. He said it is for that reason he is opposed to Dr. Speck's motion to delete the word "internationally". Dr. Harmon noted that BCBSNCA is currently involved in international activities, therefore, it is not important whether the word "internationally" is included in the policy, but he stated that he is against its deletion.

Dr. McNulty stated that the recommended corporate policy on diversification does not approve an action, but provides a policy or a sense of climate in which management will operate. He indicated that he had no difficulty with including the word "internationally". He noted that any recommended action by staff to further diversify would have to be approved by the board.

Mr. Frey noted that Dr. McNulty had made an excellent point. He also pointed out that this motion was a result of approximately two-and-a-half years of discussion by the Long-Range Planning Committee. He said that in order to establish a climate for BCBSNCA, the Committee concluded that this recommendation was appropriate. Dr. Speck maintained that BCBSNCA could be criticized for including the word "internationally" in the motion. He stated that he believes it to be wrong to subsidize the health insurance premiums of subscribers elsewhere. He said that he feels the recommendation will encourage international activities, and, therefore, the board should not allow the motion to pass. He said that at some point in the future, BCBSNCA could lose $4-$5 million as a result of underwritten benefits in another country. Therefore, the board could be criticized for raising rates because of these losses.

The motion to delete the word "internationally" from the recommended corporate policy on diversification was then defeated.

Mr. Steele then suggested that the word "locally" be deleted and replaced with the word "domestically" due to the activities of BCBSNCA's third-party administrator, National Capital Administrative Services, Inc. throughout the United States. Dr. Duvall stated that the board accepted this editorial change.

It was agreed by the board of trustees to accept the recommendation from the Long-Range Planning Committee, as amended.

It was then

VOTED: That it be BCBSNCA's policy to encourage expansion and diversification, both domestically and internationally, in those businesses that are incidental to or supportive of the purpose, business and affairs of this Corporation or its subsidiaries and affiliates so as to minimize the negative effect on the Corporation during business cycles when underwriting losses can be expected to occur.

It was then

VOTED: To accept the minutes of the January 14, 1988 meeting of the Long-Range Planning Committee, as amended.

MINUTES OF THE MEETING OF THE COMMITTEE ON FINANCE AND INVESTMENT - FEBRUARY 16, 1988

The Chairman stated that copies of the minutes of the meeting of the Committee on Finance and Investment of February 16, 1988 had been mailed to and noted by the Committee members. He said the minutes were included in the tentative agenda material for the remaining trustees.

Mr. Harrison, chairman, stated that the Committee had met with Mr. Jundt of Jundt/Capen Associates, Inc., an investment counselor who manages part of BCBSNCA's corporate equity portfolio. He stated that even with the decline in the market on October 19, 1987, BCBSNCA had a gain of 16% for 1987 in this portfolio. He noted, however, that it was unlikely that the two other investment counselors would have such good returns.

Mr. Harrison said that the Committee also met with Mr. Richard M. Ennis and Mr. Doug Patejunas of Ennis, Knupp & Associates (EKA). He explained that EKA had been hired by the Committee to review BCBSNCA's investment policies. He stated that this matter is still under study, and that the Committee will report their findings to the board at a future meeting. Mr. Harrison reminded the board that as a result of the October 19, 1987 decline in the equity market, the board had accepted to change the percentage of the portfolio invested in equities from a maximum of 70% to no more than 30%. Mr. Zajac noted that the Committee has always had a conservative investment management policy, as such policies are established under the "prudent man" rule.

Following a discussion, it was then

VOTED: To accept the minutes of the February 16, 1988 meeting of the Committee on Finance and Investment as circulated and presented.

MINUTES OF THE MEETING OF THE AD HOC BUILDING COMMITTEE - FEBRUARY 23, 1988

The Chairman stated that copies of the minutes of the meeting of the Ad Hoc Building Committee of February 23, 1988 had been mailed to and noted by the Committee members. He said the minutes were included in the tentative agenda material for the remaining trustees.

Mr. Sumter, chairman, stated that the Committee had met with Mr. Stanley D. Friedman and Mr. Edward M. McDonough of Coopers & Lybrand. He stated that the Committee was presented with voluminous material regarding the real estate market in the Washington, D. C. metropolitan area. He said that a series of charts and tables were presented, which reflected various real estate information in this area. Mr. Sumter stated that Mr. Friedman concluded that there were three options available to the Committee: 1) sale of the building; 2) a sale with a leaseback provision; and 3) a sale that represented obtaining a mortgage on the building. Mr. Sumter noted, however, that no definite decision has been reached by the Committee. He said that Mr. Friedman will be gathering additional information which will be discussed at a future meeting.

Mr. Gamble then distributed a chart titled "BCBSNCA RESERVES ANALYSIS (1981-1990)", a copy of which is attached to and made a part of these minutes.

Mr. Gamble reviewed the chart and stated that of the total amount in reserves, only $4 million pertained to the value of the building. He said that the book value of the building after depreciation is $13 million. He stated that the mortgage on the building is presently $9 million, and, thus, the impact on reserves was $4 million. He noted the steady decline in reserves since 1985, along with a steadily increasing unrecorded value of the land and building at 550 12th Street, S.W. He stated that in 1985, the corporate reserves peaked at $186 million, which represented 23% of annual subscription income. He said that if the building had been sold at that time, reserves would have been higher than justified and could have caused undesirable actions. Mr. Gamble stated that at the end of 1988, the reserves for BCBSNCA operations are projected to be approximately $74 million, whereas the unrealized building value will be in excess of $97 million. He noted that outside parties have commented that to have more than half of the total economic value of an organization invested in one property may be an unnecessary risk. Mr. Gamble noted that this risk could be the same as having half of the value of an organization invested in one stock. He stated that the purpose of the chart was to clearly demonstrate to the board the appropriateness of having the Ad Hoc Building Committee determine what BCBSNCA should do or not do regarding the building at 550 12th Street, S.W. He noted that this was a status report, and, therefore, no action was being recommended. Mr. Gamble also said that the sale of the building was not being considered in order to provide funds to cover BCBSNCA's operating losses. He said that BCBSNCA is expecting reserves to increase in 1989 and 1990, but that the same high risk will continue to exist. He stated that even though BCBSNCA will be increasing its reserves, BCBSNCA may want to consider an alternative regarding the building in 1990.

Mr. Sumter also noted that the property owned by BCBSNCA in Fairfax County, Virginia is increasing in value, but that the value of that property is not included on the "BCBSNCA RESERVES ANALYSIS (1981-1990)" chart. Dr. Harmon commented that the building, given the increasing unrealized value each year, has provided a great return for BCBSNCA.

Mr. Gamble stated that during the meeting of the Ad Hoc Building Committee, it was noted that the Corporation could be protected if the value of the building continued to increase, and an option to repurchase the building was provided for. He said that this would allow BCBSNCA to participate in future increases in the value of the building.

Following a discussion, it was then

VOTED: To accept the minutes of the February 23, 1988 meeting of the Ad Hoc Building Committee as circulated and presented.

Minutes of the Meeting of the BCBSNCA Board of Trustees - March 8, 1988

FINANCIAL STATEMENTS - JANUARY 31, 1988

Mr. Giuliani presented the financial statements as of January 31, 1988, copies of which had been mailed to the trustees.

Mr. Giuliani reviewed the Comparative Balance Sheet as of January 31, 1988, compared to January 31, 1987. During the 12-month period, he said total assets had decreased by $24,813,733.65, and he identified the major items contributing to those decreases. During the same 12-month period, he said liabilities had increased by $33,343,627,24, and he identified the significant items contributing to those increases. Mr. Giuliani said that as a result, total reserves had declined $58,157,360.89 over the last 12 months.

Mr. Giuliani stated that relative to the Comparative Statement of Earned Income and Incurred Expense for year-to-date January 31, 1988, the net income from underwriting reflected a loss of $3,207,147.20. He stated that other income and expense reflected a loss of $326,378.27 and, therefore, the excess of income over expense for this period reflected a loss of $3,533,525.47.

Mr. Giuliani stated that as of December 1987, the Allocated Operating Expense for the Federal Employee Program (FEP), which has previously been reported under Operating Expense on the Comparative Statement of Earned Income and Expense, is no longer being reported by BCBSNCA. He stated that allocated expenses are not expenses incurred by BCBSNCA, but are primarily expenses that are incurred by the National Association on behalf of the Federal Employee Program, and which have been allocated back to each Plan as underwriters of the program on a prorated basis. Mr. Giuliani stated that BCBSNCA, being the largest underwriter of the Federal Employee Program among the Blue Cross and Blue Shield Plans, receives a larger allocation than any other Plan. However, he stated that FEP-allocated expenses are seldom recorded by other Plans, and this concept is not used for other national accounts. He stated it is for that reason BCBSNCA has ceased to record this item effective December 1987. Mr. Giuliani said, therefore, the amount reflected for 1988 on the Comparative Statement of Earned Income and Expense for Allocated Operating Expense for FEP is zero, and that this will be the case throughout the year. He also noted that this change also serves to reduce Earned Subscription Charges from FEP subscribers, and, therefore, the impact of Net Income from Underwriting is zero.

Mr. Giuliani stated that in 1987, the projected losses for BCBSNCA operations were $55 million, and that the actual loss was approximately $57.4 million. He further noted that for the month of January, the loss of $3.5 million was in line with the 1988 forecasted loss of $18 million. He said, however, that the forecasted loss of $18 million could be less, if trends decline from the 15%-16% level, which were assumed in the $18 million projection. He stated that if trends exceed the 15%-16% level, the projected loss will be more than $18 million.

Following additional discussion, it was then

VOTED: To accept the financial statements dated January 31, 1988.

AUDITOR'S REPORT - DECEMBER 31, 1987

The Chairman called upon Mr. Giuliani to present the Auditor's Report for December 31, 1987. Mr. Giuliani stated that copies of the report had been mailed to the trustees with the tentative agenda material. He said the report is the consolidated report of the operations of BCBSNCA, along with the subsidiaries, which are controlled by BCBSNCA. Therefore, the Audit Report does not include the results of Access America, Inc., Emtrust, Inc. and Protocol. He said that the routine financial statements presented to the board represent the operations of BCBSNCA, and do not reflect the operations of the subsidiaries. Mr. Giuliani said that it is important to note that the Auditor's Report contained a letter to the board which stated that the auditors do not take exception to the statements of GHMSI. He stated that the Consolidated Balance Sheets reflected a reserve for protection of subscribers of $71,271,000. He stated that this is based on a reserve for the Blue Cross and Blue Shield operations as of December 31, 1987 of $91.8 million, less cumulative deficits of $20.5 million as of December 31, 1987 for subsidiaries. On the Consolidated Statements of Operations and Reserve for Protection of Subscribers, he noted that the net loss for the year 1987 was $66,481,000, of which approximately $57.4 million was from Blue Cross and Blue Shield operations, $8.0 million from operation of the subsidiaries, and $1 million from Blue Cross of Jamaica (BCJ). He also stated that the report reflected that when BCBSNCA acquired BCJ, BCJ had reserves of approximately $2 million, and, therefore, when BCBSNCA infused $5 million into BCJ's operations, its reserves increased to approximately $7 million. He stated that as of December 31, 1987, the $7 million reserves had been reduced to $6 million due to the $1 million operating loss BCJ incurred during 1987.

After further discussion, it was

VOTED: To accept the Auditor's Report dated December 31, 1987.

REPORT OF THE CHIEF EXECUTIVE OFFICER

Mr. Gamble reviewed his report, copies of which had been mailed to the trustees.

FEP Open Season Enrollment

Mr. Gamble stated that as a result of the FEP Open Season which was recently completed, BCBSNCA realized a loss of 9,926 subscribers under High Option coverage, while 9,332 subscribers joined the Standard Option

program, resulting in a net loss to BCBSNCA of 594 subscribers. He said that at this same time during last year's Open Season, 4,642 subscribers had left High Option, while 5,067 subscribers had joined Standard Option, for a net gain of 425 subscribers.

Mr. Gamble noted that nationally, the System lost 88,406 subscribers under High Option coverage, while 90,650 subscribers joined Standard Option, providing a net gain of 2,244 subscribers. He stated that during the prior Open Season, 40,047 subscribers left High Option, while 47,220 subscribers joined Standard Option, for a net gain of 7,173 subscribers.

Medical Underwriting - Groups of 2-9 Subscribers

Mr. Gamble stated that following a period of study and analysis extending over several months, BCBSNCA staff had expanded its medical underwriting policy to include groups in the 2-9 size category. He said that medical underwriting is a procedure which elicits answers to health questions, and is designed to reduce incidents of adverse selection and underwriting risk. He noted that BCBSNCA's medical underwriting practice will continue to focus on applicants' responses to 17 health-related questions, and does not require complete medical histories nor physical examinations. Mr. Gamble stated that this practice will apply to those groups which are enrolled on and after March 1, 1988. He said that group accounts enrolled before that date will not be subject to medical underwriting, although employee additions to those groups will be subject to medical underwriting effective June 1, 1988.

Mr. Gamble noted that prior to March 1, 1988, BCBSNCA's medical underwriting policy was limited to non-group applicants, and to group Major Medical coverage in instances where Major Medical benefits are added to existing Blue Cross and Blue Shield coverage. He said that this revised policy is compatible with industry-wide practices among BCBSNCA's competitors, and is expected to have a favorable impact on BCBSNCA's claims expense.

Dental Network of America

Mr. Gamble stated that at the recent special meeting of the shareholders of Dental Network of America, he had been elected chairman of the board to succeed William E. Ryan, who recently retired from his position as president of BCS Financial Corporation.

Establishment of BPS, Inc.

Mr. Gamble stated that during the board meeting of March 10, 1987, staff advised the board of the need to establish a national account delivery capability which would be marketed to the Blue Cross and Blue Shield System of Plans. He said that the board was advised that four Plans--Blue Cross and Blue Shield of Illinois, Blue Cross and Blue Shield of Missouri, Community Mutual Insurance Company of Cincinnati, Ohio, and BCBSNCA--had

expressed an interest in pursuing the development of this capability, which was projected to cost up to $10 million over the next several years, and that other Plans would be offered an opportunity to invest in the venture.

Mr. Gamble stated that accordingly, at the March 10, 1987 board meeting, staff was authorized to invest up to $2.5 million in this venture.

He stated that during this past fall, as a result of an offering made to all other Plans, 18 additional Plans decided to invest a total of nearly $2.9 million in an organization named BPS, Inc., which will be responsible for the national account delivery system available to all Plans. Mr. Gamble said that as a result, the original four Plans, at this time, will only need to invest approximately $7.1 million in total. He stated that, accordingly, BCBSNCA's investment will initially only be one-fourth of that amount, or nearly $1,775,000.

Mr. Gamble stated that on February 4, 1988, at the initial BPS, Inc. shareholders' meeting, he had been elected as one of the nine board members. He said that the organizational board meeting of BPS, Inc. was also held on that date.

Mr. Gamble stated that as a result of an interim organization put in place by the original four Plans, the first phase of the BPS systems development has been completed, the first account implemented in January 1988, and the second account scheduled for implementation on May 1, 1988.

Blue Cross of Jamaica

Mr. Gamble stated that on Friday, February 19, 1988, the board of trustees of Blue Cross of Jamaica met in Miami, Florida. He noted that when the minutes of the meeting are finalized, they will be distributed to the BCBSNCA trustees for their information.

Assembly of Plans

Mr. Gamble stated that on February 4-5, 1988, the third meeting of the Assembly of Plans took place. He said that essentially, the Committee on Service Marks and Exclusive Service Areas, which he serves on, was seeking direction from the Assembly on six alternatives. He stated that these alternatives, which were not mutually exclusive, were as follows:

1. Eliminate exclusive service areas
2. Revocation of License Agreement and return of ownership of marks to the Plans (concurrent use)
3. Status quo - Continue as system has in the past and react to future developments as they arise
4. Litigate exclusive service areas and other open questions
5. Move towards consolidation
6. Strengthening license and enforcement policies

Mr. Gamble stated that the Assembly endorsed the sixth option for purposes of further debate by the Committee, as well as setting a direction for the other three Committees to begin to function. He said that the other three Committees are the National Account Committee, the Plan Mission and Structure Committee, and the Role of the Association Committee. He said that the next meeting of the Assembly will be held on April 21-22, 1988.

Price Waterhouse Report on Internal Accounting and Management Controls

Mr. Gamble stated that as part of BCBSNCA's annual audit process, Price Waterhouse, auditor for BCBSNCA, has submitted a management letter in which it stated that its study and evaluation of BCBSNCA disclosed no condition which it believed to be a material weakness.

Conflict of Interest Statements - Key Employees

Mr. Gamble stated that Conflict of Interest Statements had been completed and returned by 322 key employees. He stated that he had reviewed these statements, none of which indicated a conflict of interest.

It was then

VOTED: To accept the Report of the Chief Executive Officer dated March 8, 1988.

LEGAL COUNSEL'S REPORT

Mr. Steele presented the Legal Counsel's Report, copies of which had been mailed to the trustees.

Mr. Steele stated that the most significant legal matter pending was the Dunston appeal. He noted that this is a case in which the Superior Court granted BCBSNCA's motion for summary judgment. He said that the issues on appeal involve whether the tort of bad faith claims denial exists in the District, and, if it does, whether it is preempted by the Federal Employees Health Benefits Act.

Beach v. GHMSI

Mr. Steele stated that this case is of interest because it is the third case within the last several years brought by a patient of Dr. Norman Cowan. He said that the issue in all three cases was the reasonableness of the fee arrived at by BCBSNCA in connection with Dr. Cowan's distraction augmentation mammoplasty surgery.

Infertility Associates International, Inc. v. GHMSI

Mr. Steele stated that this case was settled and dismissed. He explained that Infertility Associates International, Inc. (IAI) dropped its claims

against GHMSI for payment of benefits for its pregnant "employees". He said that GHMSI dropped its RICO claim against IAI for alleged racketeering. He stated that GHMSI kept the subscription income of approximately $7,000.

It was then

VOTED: To accept the Legal Counsel's Report as presented March 8, 1988.

REPORT ON BANK ACCOUNTS

Mr. Giuliani stated that copies of the report titled "Report on Bank Accounts", dated March 8, 1988, had been mailed to the trustees with the tentative agenda material.

He explained that at the organizational meeting of the Group Hospitalization and Medical Services, Inc. (GHMSI) board of trustees on January 8, 1985, the board adopted a resolution concerning bank accounts and vouchers which included a provision to notify the board of any accounts opened for the deposit or disbursement of funds to meet the operating needs of the corporation. He said, however, that due to an oversight, the reporting to the board on bank accounts opened had not been routinely done, and, therefore, attached to the report was a listing showing bank accounts which had been opened by BCBSNCA since January 8, 1985, giving specific information such as: account name, account number, bank name, date opened, primary purpose of the account, and amount of the initial deposit made to that account. Mr. Giuliani said that in the future, staff would report to the board routinely all accounts opened in the name of Group Hospitalization and Medical Services, Inc. or Blue Cross and Blue Shield of the National Capital Area.

It was then

VOTED: To accept the Report on Bank Accounts dated March 8, 1988.

OTHER BUSINESS

1988 Board Seminar

Mr. Gamble stated that the 1988 Annual Board of Trustees Seminar will be held in Colonial Williamsburg, Virginia on May 6, 7 and 8, noting that arrival would be on May 5.

He stated that the agenda for the 1988 seminar will primarily be topics of international origin. He said that as a result of this seminar, the board will be informed of all of BCBSNCA's international activities. Mr. Gamble

then named the executives who will be making a presentation at the seminar, along with Francois Balanca from BCBSNCA's Paris office and George E. Goodwin, Manager of BCBSNCA's United States Virgin Islands Processing Center. Mr. Gamble noted that staff will convey to the board BCBSNCA's strategies regarding the international marketplace. He also noted that information concerning the Seminar would be distributed to trustees at a later date.

District IX Blue Cross and Blue Shield Conference

Mr. Gamble said that he had been asked to speak in Phoenix, Arizona on March 10, 1988 to trustees and executives from Blue Cross and Blue Shield Plans in the Southwest regarding international activities.

Resignation of Blue Cross of Jamaica Board Member

Mr. Gamble stated that Mr. Harrison has resigned from the board of Blue Cross of Jamaica (BCJ), and at the next meeting of BCJ, Mr. Lutrelle F. Parker will be named to fill the vacancy left by Mr. Harrison.

Possible Consolidation with Blue Cross and Blue Shield of West Virginia, Inc.

Mr. Gamble also advised the board that he had been approached by James W. Heaton, President of Blue Cross and Blue Shield of West Virginia, Inc. (BCBSWVI) to consider a consolidation with BCBSNCA. He stated that Mr. Heaton had indicated that three Plans have been selected for consideration to consolidate with BCBSWVI. Mr. Gamble stated that as a result of their meeting, Mr. Heaton seems to be favorably inclined to BCBSNCA. He said that they are now trying to schedule a meeting which will include he, Mr. Heaton, Dr. Duvall and BCBSWVI's chairman. He noted, however, that in his opinion, this would be more of a pure merger than the Utah proposal.

Dr. McNulty asked about the status of BCBSWVI's reserves. Mr. Gamble responded that BCBSWVI's reserve levels are weak. Dr. McNulty noted that this consolidation would reflect contiguity. He also noted the great number of patients who were referred from West Virginia to Georgetown University Hospital, in the District.

ADJOURNMENT

The meeting was adjourned at 8:40 p.m.

BCDSNCA RESERVES ANALYSIS (1981 - 1990)
(000's)

YEAR	(A) EARNED SUBSCRIPTION INCOME	(B) NET ANNUAL INCOME/(LOSS)	(C) YEAR END RESERVES	(D) UNRECORDED VALUE OF LAND & BLDG [1]	(E) RESERVES [2] AS % OF INCOME (C)/(A)	(F) UNREC.VAL.OF LAND & BLDG AS % OF INCOME (D)/(A)	(G) RES.+UNREC.VAL. OF LAND & BLDG AS % OF INCOME [(C)+(D)]/(A)
1981	$682,154	($9,568)	$94,997	$18,452	14%	3%	17%
1982	$713,090	$6,797	$101,791	$26,196	14%	4%	18%
1983	$726,607	$25,589	$127,383	$33,942	18%	5%	22%
1984	$768,158	$27,813	$155,196	$47,210	20%	6%	26%
1985	$808,132	$31,139	$186,335	$60,179	23%	7%	31%
1986	$905,515	($34,930)	$146,863 [3]	$73,747	16%	8%	21%
1987	$918,773	($57,109)	$91,792 [3]	$87,015	10%	9%	19%
1988(est)	$1,090,766	($17,370)	$74,422	$97,784	7%	9%	16%
1989(est)	$1,269,379	$4,780	$79,202	$109,552	6%	9%	15%
1990(est)	$1,171,155	$16,786	$95,988	$122,421	7%	8%	15%

[1] Represents the difference between the market value of Land & Building (550 12th St.,S.W.) and the $4.0 million included in Reserves (Book Value less Mortgage). Market Value assumes $25.0 million on 5/30/80, doubling to $50.0 million on 12/31/83, redoubling to $100.0 million on 12/31/87 and increasing at an annual rate of 10% thereafter.

[2] Reserve floor is considered to be 5% of Earned Subscription Income.

[3] YEAR END RESERVES for 1986 and 1987 include Unrealized Losses on Marketable Equity Securities of $4.542 million and $2.204 million respectively.

GROUP HOSPITALIZATION AND MEDICAL SERVICES, INC.
INTERNATIONAL DIVISION
880 12TH STREET, S.W.
WASHINGTON, D.C. 20065
FAX (202) 488-1604
TELEX 64133

Senate Permanent Subcommittee on Investigations

EXHIBIT # 30f.

ORIGINAL

P1013

Declaration Number

DECLARATION UNDER FACULTATIVE TREATY

WE HEREBY DECLARE THE FOLLOWING UNDER THE ABOVE FACULTATIVE TREATY:

1.	INSURED:	Association Internationale de Prevoyance Societe (AIPS)
2.	TYPE:	Medical Full Service Program
3.	INTEREST:	To cover various subscribers of AIPS' Ambassador Products for medical expenses arising out of accident and/or illnesses
4.	LIMITS:	Net Rates received by Reassured
5.	TERRITORIAL LIMITATION:	Worldwide
6.	CONDITIONS:	As Original
7.	PREMIUM PAYABLE:	As Original
8.	OVERRIDING COMMISSION:	Nil
9.	PROFIT COMMISSION:	Nil
10.	LINE DECLARED:	100%
11.	DATE OF DECLARATION:	23 January 1992 but effective 1 January 1990

FOR GROUP HOSPITALIZATION AND MEDICAL SERVICES, INC.

Accepted 23/1/92

INT. HEALTH BENEFITS (IRL) LTD.

GHMSI 25A: 00308

REASSURED	International Health Benefits (Ireland) Limited and/or their Subsidiary and/or Associate and/or Affiliated Companies.
PERIOD	Permanent Contract Commencing DTBA, subject to 3 months notice of cancellation, effective 31st December, any year, but not prior to 31st December, 1991
TYPE	100% Priority Facultative Treaty
INTEREST	To accept all Medical Direct and Reinsurance business as declared hereunder by the Reassured. and agreed by Reinsurers hereon.
LIMITS	As per individual Policy's/Contract's declared hereunder Reassured to have option of NIl Retention
CONDITIONS	All terms, clauses, conditions and exclusions as per original policies and to follow the settlements of the Reassured in all respects, as far as the applicable hereunder. Claims Control Clause to be agreed. Cut Through Clause. Interlocking Clause. Currency Conversion Clause - All amounts, unless otherwise agreed, shall be settled in United States Dollars at the Rate of Exchange applicable when the Reassured either received or physically settled amounts falling due to under these declarations. Local Jurisdiction Clause, as far as applicable.
WORDING	To be agreed Leading Underwriter only
BORDEREAU	Quarterly
PREMIUM	Original net rates received by Reassured
OVERRIDING COMMISSION	T.B.A.
ACCOUNTS	Quarterly
PROFIT COMMISSION	T.B.A.
SECURITY	100% Group Hospitalization and Medical Services, Inc.

Commence 1/1/90

J.F. Gamble 100% 16/8/90

FOR GROUP HOSPITALIZATION AND MEDICAL SERVICES, INC.

REASSURED	Group Hospitalization and Medical Services, Inc. and/or their Subsidiary and/or Associate and/or Affiliated Companies.
PERIOD	Permanent Contract Commencing DTBA, subject to 3 months notice of cancellation, effective 31st December, any year, but not prior to 31st December, 1991
TYPE	100% Priority Facultative Treaty
INTEREST	To accept all Medical Direct and Reinsurance business as declared hereunder by the Reassured. and agreed by Reinsurers herein
LIMITS	As per individual Policy's/Contract's declared hereunder Reassured to have option of Nil Retention
CONDITIONS	All terms, clauses, conditions and exclusions as per original policies and to follow the settlements of the Reassured in all respects, as far as the applicable hereunder. Claims Control Clause to be agreed. Cut Through Clause. Interlocking Clause. Currency Conversion Clause - All amounts, unless otherwise agreed, shall be settled in United States Dollars at the Rate of Exchange applicable when the Reassured either received or physically settled amounts falling due to under these declarations. Local Jurisdiction Clause, as far as applicable.
WORDING	To be agreed Leading Underwriter only
BORDEREAU	Quarterly
PREMIUM	Original net rates received by Reassured
OVERRIDING COMMISSION	T.B.A.
ACCOUNTS	Quarterly
PROFIT COMMISSION	T.B.A.
SECURITY	100% International Health Benefits (Ireland) Limited.

Commence 1/1/90

E. Phillips 100%

For I... ...ENEFITS (IRL) LTD

16/8/90

(14)

BLUE CROSS OF JAMAICA
85 Hope Road
Kingston 6, Jamaica, W.I.

DIRECTORS

(12 Directors consisting of 8 GHMSI and 4 Jamaican representatives)

J. P. Gamble
B. W. Giuliani
C. G. Chapman
I. Laster, Jr.
R. E. Petersen
S. J. Pace
L. F. Parker
L. W. Zajac
D. Crawford (Jamaica)
L. P. Knight (Jamaica)
H. W. Lowe (Jamaica)
U. H. Salmon (Jamaica)

OFFICERS

Chairman:	J. P. Gamble
President, CEO, Secretary:	H. W. Lowe
Vice President, Finance:	N. Stewart
Vice President Marketing:	A. Stewart-Gaynor
Vice Chairman:	U. H. Salmon

Affiliation:	Group Hospitalization and Medical Services Inc. (July 24, 1987)
Incorporated Date:	December 26, 1956
Where:	Jamaica
Employees:	140
Type of Company:	Operational
Business:	As Jamaica's largest health insurer, Blue Cross of Jamaica provides health benefits for 180,000 residents of Jamaica. Individuals, small and large employers alike benefit from hospital, medical, dental and optical benefits.

May 31, 1992

CAPITAL AREA SERVICES COMPANY, INC.
550 12th Street, S.W.
Washington, D. C. 20065

DIRECTORS	OFFICERS	
J. P. Gamble	President:	S. J. Pace
B. W. Giuliani	Vice President:	S. S. Kousin
D. H. Kestel	Secretary:	R. A. Cook
S. J. Pace	Treasurer:	W. B. Poffenberger
R. A. Cook		
W. B. Poffenberger		

Ownership:	100% The GHMSI Companies, Inc.
Incorporated Date:	March 27, 1991
Where:	District of Columbia
Employees:	16 (Assigned BCBSNCA employees for CASCI-WVA relocation project)
Type of Company:	Legal
Business:*	Provides claims administration for BCBSNCA in West Virginia.

* NOTE: A reorganization plan to merge CASCI-D.C. and CASCI-WVA will be submitted to the respective boards of directors before the end of 1992.

May 31, 1992

CAPITAL AREA SERVICES COMPANY, INC.
200 Kanawha Boulevard, East
Charleston, West Virginia 25337

DIRECTORS	OFFICERS	
S. J. Pace	Chairman:	S. J. Pace
W. B. Poffenberger	Vice Chairman:	W. B. Poffenberger
	Secretary and Treasurer:	W. B. Poffenberger
	President:	S. J. Pace
	Vice President:	S. S. Kousin

Ownership:	100% The GHMSI Companies, Inc.
Incorporated Date:	March 4, 1992
Where:	Charleston, West Virginia
Employees:	170
Type of Company:	Service (not for profit)
Business:	Provides claims administration for BCBSNCA in a lower cost area.

* NOTE: A reorganization plan to merge CASCI-D.C. and CASCI-WVA will be submitted to the respective boards of directors before the end of 1992.

GROUP HOSPITALIZATION AND MEDICAL SERVICES, INC.
INTERNATIONAL DIVISION
550 12th Street, S.W.
Washington, D. C. 20065

DIRECTORS

(7 Directors)

J. P. Gamble
B. W. Giuliani
R. B. Groppe
D. H. Kestel
R. A. Cook
S. J. Pace
W. B. Poffenberger

OFFICERS

Chairman:	J. P. Gamble
Vice Chairman:	B. W. Giuliani
President:	R. B. Groppe
Secretary:	R. A. Cook
Treasurer:	W. B. Poffenberger

Formed
Date: October 1, 1988
Where: District of Columbia

Employees: 37

Type of Company: Operating

Business: The International Division is an unincorporated organization operating as a division of GHMSI. Through GHMSI subsidiary companies, it markets and administers medical insurance products for multinational companies and expatriate opoulations (people living outside their home countries) throughout the world; it also operates the International Hospital Network.

PROFESSIONAL OFFICE SYSTEMS, INC.
Springfield Office Center
6551 Loisdale Court
Springfield, Virginia 22150

DIRECTORS

(4 or more Directors)

J. P. Gamble
B. W. Giuliani
S. J. Pace
W. B. Poffenberger
D. H. Kestel
R. A. Cook
M. F. Long

OFFICERS

Chairman:	J. P. Gamble
Vice Chairman:	B. W. Giuliani
Secretary:	R. A. Cook
Treasurer:	W. B. Poffenberger
President:	M. F. Long
Vice President:	J. Morrone

Ownership: 100% The GHMSI Companies, Inc.

Incorporated
Date: June 27, 1985
Where: District of Columbia

Employees: 20

Type of Company: Operational

Business: POS offers data processing services, computer hardware and software and office systems advice to physicians, dentists and hospitals.

POS promotes electronic claims filing, which eliminates the need for paper claims. It also conducts seminars to explain how electronic claims filing can reduce paperwork, eliminate errors and speed payments.

PROTOCOL ADMINISTRATIVE SERVICES
8180 Greensboro Drive
Suite 800
McLean, Virginia 22102

DIRECTORS

J. P. Gamble
B. W. Giuliani
H. W. Riley, Jr.
S. J. Pace
D. H. Kestel
R. A. Cook
W. B. Poffenberger

OFFICERS

Chairman:	J. P. Gamble
Vice Chairman:	B. W. Giuliani
Secretary:	R. A. Cook
Treasurer:	W. B. Poffenberger
President:	H. W. Riley, Jr.
Vice President:	P. T. Tihansky

Ownership:	100% The GHMSI Companies, Inc.
Incorporated Date:	April 19, 1991
Where:	District of Columbia
Employees:	0
Type of Company:	Legal
Business:	To establish and operate a third party administrator and administrative services organization.

PROTOCOL, INC.
8180 Greensboro Drive
Suite 800
McLean, Virginia 22102

DIRECTORS

(3 or more Directors)

J. P. Gamble
B. W. Giuliani
S. J. Pace
W. B. Poffenberger
D. H. Kestel
R. A. Cook
H. W. Riley, Jr.

OFFICERS

Chairman:	J. P. Gamble
Vice Chairman:	B. W. Giuliani
Secretary:	R. A. Cook
Treasurer:	W. B. Poffenberger
President:	H. W. Riley, Jr.

Ownership: 100% The GHMSI Companies, Inc.

Incorporated
Date: April 22, 1986 (amended May 18, 1988)
Where: District of Columbia

Employees: 57

Type of Company: Operational

Business: PROTOCOL administers customized health care plans for association groups. Through PROTOCOL's affiliation with PPO networks across the U.S., members of association groups gain access to selected health care providers and facilities nationwide.

PROTOCOL also provides access to medical care for the international community -- employees of the diplomatic corps., the foreign service, international organizations and foreign-owned companies -- residing in the U.S. PROTOCOL's network of multilingual health care providers and account representatives specialize in catering to the unique needs of the international community.

LOCATIONS OF GHMSI COMPANIES

UNITED STATES
Washington, D.C
American Capital Life Insurance Company
American Capital Service Corporation
Blue Cross and Blue Shield of the National Capital Area (GHMSI)
Capital Area Services Company, Inc.
International Consulting Service, Inc.
International Health Benefits, Inc.
The GHMSI Companies
GHI Nominee, Inc.
GHMSI Partnership 1
National Capital Insurance Agency (incorporated in Virginia; current location is D.C.)
TravelCare (Duncan Travel Services)
World Access, Inc.

Virginia
Access America (incorporated in Delaware; current location is Virginia)
CapitalCare, Inc.
CapitalCare Administrative Services, Inc.
EMTRUST (incorporated in D.C.; current location is Virginia)
EMTRUST Reinsurance Company (incorporated in D.C.; current location is Virginia)
Belle Haven Service Corporation (incorporated in D.C.; current location is Virginia)
Health Management Strategies International, Inc. (incorporated in D.C.; current location is Virginia)
National Capital Administrative Services, Inc. (incorporated in D.C.; current location is Virginia)
NCAS Insurance Agency (incorporated in D.C.; current location is Virginia)
Professional Office Systems, Inc. (incorporated in D.C.; current location is Virginia)
Protocol, Inc. (incorporated in D.C.; current location is Virginia)
Protocol Administrative Services (incorporated in D.C.; current location is Virginia)
World Access Health Care Services (incorporated in D.C.; current location is Virginia)
World Access Service Corporation

Utah
First Continental Life and Accident Company

West Virginia
Capital Area Services Corporation, Inc.

AUSTRALIA
World Access Australasia Pty. Limited

BARBADOS
National Capital Reinsurance Company, Inc.

CANADA
World Access Canada, Inc.
Waterloo Insurance Associates

CHANNEL ISLANDS
International Insurance Associates, Ltd.
International Health Benefits, Ltd. (Guernsey)

ENGLAND
World Access Limited

FRANCE
Group Hospitalization and Medical Services International, S.A.
International Claims Center E.U.R.L.

IRELAND
International Health Benefits (Ireland) Ltd.
National Capital Reinsurance Limited
World Access Ireland

JAMAICA
Blue Cross of Jamaica

NEW GUINEA
World Access Medical Services

PANAMA
International Health Benefits of Panama, Inc.

SINGAPORE
World Access (Asia) Pte., Ltd.

FUNCTIONAL BREAKDOWN OF GHMSI COMPANIES

Definition of Terms

Operational:	*A subsidiary established to provide products or services to external customers.*
Legal:	*A subsidiary established to meet some legal or regulatory requirement.*
Service.	*A subsidiary established to provide products or services within the company. These were established to provide an easy way to isolate revenues and expenses for management review.*

Operational
American Capital Life Insurance Company
Blue Cross and Blue Shield of the National Capital Area (GHMSI)
Blue Cross of Jamaica
CapitalCare, Inc.
EMTRUST
EMTRUST Reinsurance Company, Inc.
First Continental Life and Accident Company
Group Hospitalization and Medical Services International, S.A.
Health Management Strategies
International Health Benefits, Inc.
International Health Benefits (Ireland), Ltd.
National Capital Administrative Services, Inc.
National Capital Insurance Agency, Inc.
National Capital Reinsurance Company, Inc. (Barbados)
National Capital Reinsurance Limited (Ireland)
Professional Office Systems, Inc.
Protocol, Inc.
World Access, Inc.
World Access (Asia) Pte., Ltd.
World Access Medical Services
World Access Australasia Pty. Limited
World Access Canada
TravelCare (Duncan Travel Services, a division of World Access)

Legal
Access America
American Capital Service Corporation
CapitalCare Administrative Services, Inc.
Capital Area Services Company, Inc. (DC)
Belle Haven Service Corporation (subsidiary of EMTRUST)
The GHMSI Companies
GHI Nominee, Inc.
GHMSI Partnership I
International Health Benefits Ltd. (Guernsey)
International Health Benefits of Panama, Inc.
International Insurance Associates, Ltd.
International Claims Center E.U.R.L.
NCAS Insurance Agency
Protocol Administrative Services
World Access Health Care Services
World Access Ireland Limited
World Access Limited (UK)
Waterloo Insurance Associates

(functional breakdown, continued)

Service
Capital Area Services Company, Inc. (West Virginia)
International Consulting Services, Inc.
World Access Service Corporation

BLUE CROSS AND BLUE SHIELD OF THE NATIONAL CAPITAL AREA
550 12th Street
Washington, D. C. 20065

TRUSTEES

Charlotte G. Chapman
Charles P. Duvall, M.D.
Ralph W. Frey
Joseph P. Gamble
Benjamin W. Giuliani
Thomas R. Harrison
George W. Jones, M.D.
Ira Laster, Jr., Ph.D.
Peter D. LeNard, M.D.
Robert C. Mayer
Floretta D. McKenzie, Ph.D.
Victor E. Millar
Charles T. Nason
Lutrelle F. Parker
Benjamin S. Pecson, M.D.
Robert E. Petersen
John E. Sumter, Jr.
Mallory Walker
David S. Wiggin
Leo W. Zajac

Chartered Date:	Chartered as Group Hospitalization, Inc. on August 11, 1939. Corporation is currently trading as Blue Cross and Blue Shield of the National Capital Area.
Where:	United States Congress
Employees:	2,280
Type of Company:	Operational (not for profit)
Business:	For more than 55 years, BCBSNCA has provided prepaid health plans to the Washington, D. C. area. It is the largest provider of health care coverage in the area, with over 1.1 million subscribers.

OFFICERS

Chairman:	C. P. Duvall, M.D.
Vice Chairman:	J. P. Gamble
President:	B. W. Giuliani
Corporate Secretary:	R. A. Cook
Corporate Treasurer:	W. B. Poffenberger
Executive Vice President:	S. J. Pace
Senior Vice Presidents:	R. A. Cook P. R. Kongstvedt, M.D. M. F. Long W. B. Poffenberger
Vice Presidents:	R. W. Blosse G. A. Brown R. L. Cunningham R. J. Huber J. P. Kahl J. D. Karabin S. L. Kousin G. K. Morris, M.D. S. Sieverts E. P. Von Hoene D. L. Ward

GROUP HOSPITALIZATION AND MEDICAL SERVICES, INC.
500 12th Street, S.W.
Washington, D. C. 20065

TRUSTEES

Charlotte G. Chapman
Charles P. Duvall, M.D.
Ralph W. Frey
Joseph P. Gamble
Thomas R. Harrison
Ira Laster, Jr., Ph.D.
Peter D. LeNard, M.D.
Robert C. Mayer
Victor E. Millar
Charles T. Nason
Lutrelle F. Parker
Benjamin S. Pecson, M.D.
Robert E. Petersen
Mallory Walker
David S. Wiggin
Leo W. Zajac

Chartered
Date: August 11, 1939 (amended October 17, 1984)
Where: United States Congress

Employees: 2,496

Type of Company: Operational

Business: GHMSI is licensed by the Blue Cross and Blue Shield Association to use the Blue Cross and Blue Shield name and mark in the Washington, D.C. area and, in that capacity, trades as Blue Cross and Blue Shield of the National Capital Area. GHMSI is charted by the United States Congress, and is the parent corporation with eight operating divisions/groups or eight lines of business. It currently has eight divisions: Assistance Services Group, Association and Special Risks Division, Blue Cross of Jamaica, Blue Cross and Blue Shield of the National Capital Area Division, GHMSI International Division, Health Management Services Division, Insurance Group, and Third-Party Administrator Division.

OFFICERS

Chairman:	C. P. Duvall, M.D.
Vice Chairman:	T. R. Harrison
President:	J. P. Gamble
Corporate Secretary:	R. A. Cook
Corporate Treasurer:	W. B. Poffenberger
Executive Vice President:	B. W. Giuliani
Senior Vice Presidents:	R. A. Cook D. H. Kestel S. J. Pace W. B. Poffenberger
Vice Presidents:	R. W. Blosse G. A. Brown R. L. Cunningham G. T. Dunlop Ecker S. Edelstein, M.D. R. B. Groppe W. G. Hendren R. J. Huber J. P. Kahl J. D. Karabin P. R. Kongstvedt, M.D. S. L. Kousin M. F. Long H. W. Riley, Jr. E. S. Shields S. Sieverts E. P. Von Hoene J. H. Waller D. L. Ward

ACCESS AMERICA, INC.
6600 West Broad Street
2nd Floor
Richmond, Virginia 22230

DIRECTORS

(7 Directors)

J. P. Gamble
B. W. Giuliani
S. J. Pace
W. B. Poffenberger
S. Edelstein, M.D.
R. A. Cook
L. A. Wilson

OFFICERS

Chairman:	J. P. Gamble
Vice Chairman:	B. W. Giuliani
Secretary:	R. A. Cook
Assistant Secretary:	M. O'Doherty
Treasurer:	W. B. Poffenberger
President:	S. Edelstein, M.D.
Senior V. P.:	L. A. Wilson
Vice President:	J. Ansell
	B. Godlin
	J. Rocket

Ownership: 100% Group Hospitalization and Medical Services, Inc.
(as of August 3, 1990)

Incorporated
Date: April 24, 1985
Where: Delaware

Employees: 10

Type of Company: Legal

Business: Formerly sales and marketing of insurance and assistance products to the travel and financial industries. Currently, dormant functions now performed by World Access Service Corporation.

AMERICAN CAPITAL LIFE INSURANCE COMPANY
800 9th Street, S.W.
Washington, D. C. 20024

DIRECTORS

(7 to 15 Directors)

J. P. Gamble
B. W. Giuliani
S. J. Pace
W. B. Poffenberger
D. H. Kestel
R. A. Cook
G. S. Johnson

OFFICERS

Chairman:	J. P. Gamble
Vice Chairman:	B. W. Giuliani
Secretary:	R. A. Cook
Treasurer:	W. B. Poffenberger
President, CEO:	D. H. Kestel
Vice President:	G. S. Johnson
Asst. Treasurer:	G. S. Johnson

Ownership: 98% The GHMSI Companies, Inc.
(acquired February 8, 1988)
2% Others

Incorporated
Date: March 22, 1960
Where: District of Columbia

Employees: 2

Type of Company: Operational

Business: AMCAP underwrites group life, accidental death and dismemberment, short and long term disability and dependent life insurance products.

AMCAP was founded in 1960 and purchased by GHMSI in 1988. AMCAP works closely with the National Capital Life Insurance Agency, Inc., also a GHMSI affiliate, to design and provide benefit plans that satisfy business clients' insurance and financial planning needs. AMCAP currently has more than $400 million of insurance in force.

AMERICAN CAPITAL SERVICE CORPORATION
800 9TH Street, S.W.
Washington, D. C. 20024

DIRECTORS	OFFICERS	
J. P. Gamble	Chairman:	J. P. Gamble
B. W. Giuliani	Vice Chairman:	B. W. Giuliani
D. H. Kestel	President:	D. H. Kestel
W. B. Poffenberger	Treasurer:	W. B. Poffenberger
R. A. Cook	Secretary:	R. A. Cook
S. J. Pace		

Ownership: 100% The GHMSI Companies, Inc.

Incorporated
Date: November 1, 1989
Where: District of Columbia

Employees: None

Type of Company: Legal

Business: Owns multiple employer insurance trust

American Capital Service Corporation was formed to allow AMCAP to provide lower prices by grouping selected accounts within this corporation for rating purposes. This subsidiary is a legal entity required to meet certain laws and regulations.

BELLE HAVEN SERVICE CORPORATION
Suite 725
5845 Richmond Highway
Alexandria, Virginia 22303

DIRECTORS

(6 Directors)

J. P. Gamble
B. W. Giuliani
J. P. O'Brien
J. R. Sielert
J. K. Singleton
D. H. Kestel

OFFICERS

Chairman:	J. K. Singleton
Vice Chairman:	J. P. Gamble
Secretary:	B. W. Giuliani
Treasurer:	J. P. O'Brien

Ownership: 100% EMTRUST, Inc.

Incorporated
Date: June 8, 1989
Where: District of Columbia

Employees: None

Type of Company: Legal

Business: Trustee for Voluntary Employee Benefit Association.

A legal entity established to group selected accounts to lower rates.

BLUE CROSS OF JAMAICA
85 Hope Road
Kingston 5, Jamaica, W.I.

DIRECTORS

(12 Directors consisting of
8 GHMSI and 4 Jamaican
representatives)

J. P. Gamble
B. W. Giuliani
C. G. Chapman
I. Laster, Jr.
R. E. Petersen
S. J. Pace
L. F. Parker
L. W. Zajac
D. Crawford (Jamaica)
L. P. Knight (Jamaica)
H. W. Lowe (Jamaica)
U. H. Salmon (Jamaica)

OFFICERS

Chairman:	J. P. Gamble
President, CEO, Secretary:	H. W. Lowe
Vice President, Finance:	N. Stewart
Vice President Marketing:	A. Stewart-Gaynor
Vice Chairman:	U. H. Salmon

Affiliation: Group Hospitalization and Medical Services Inc.

Incorporated
Date: December 26, 1956
Where: Jamaica

Employees: 140

Type of Company: Operational

Business: As Jamaica's largest health insurer, Blue Cross of Jamaica provides health benefits for 180,000 residents of Jamaica. Individuals, small and large employers alike benefit from hospital, medical, dental and optical benefits.

CAPITAL AREA SERVICES COMPANY, INC.
550 12th Street, S.W.
Washington, D. C. 20065

DIRECTORS	OFFICERS
J. P. Gamble	President: S. J. Pace
B. W. Giuliani	Vice President: S. S. Kousin
D. H. Kestel	
S. J. Pace	
R. A. Cook	
W. B. Poffenberger	

Ownership:	100% The GHMSI Companies, Inc.
Incorporated Date:	March 27, 1991
Where:	District of Columbia
Employees:	75
Type of Company:	Legal
Business:*	Provides claims administration for BCBSNCA in West Virginia.

* NOTE: A reorganization plan to merge CASCI-D.C. and CASCI-WVA will be submitted to the respective boards before the end of 1992.

May 31, 1992

CAPITAL AREA SERVICES COMPANY, INC.
200 Kanawha Boulevard, East
Charleston, West Virginia 25337

DIRECTORS

S. J. Pace
W. B. Poffenberger

OFFICERS

Chairman:	S. J. Pace
Vice Chairman:	W. B. Poffenberger
Secretary and Treasurer:	W. B. Poffenberger
President:	S. J. Pace
Vice President:	S. S. Kousin

Ownership:	100% The GHMSI Companies, Inc.
Incorporated Date:	March 4, 1992
Where:	Charleston, West Virginia
Employees:	268
Type of Company:	Service (not for profit)
Business:	Provides claims administration for BCBSNCA in a lower cost area.

* NOTE: A reorganization plan to merge CASCI-D.C. and CASCI-WVA will be submitted to the respective boards before the end of 1992.

May 31, 1992

CAPITALCARE ADMINISTRATIVE SERVICES, INC.
Ninth Floor
Tysons International Plaza
1921 Gallows Road
Vienna, Virginia 22182

DIRECTORS

(5 or more Directors)

J. P. Gamble
B. W. Giuliani
S. J. Pace
W. B. Poffenberger
D. H. Kestel
R. A. Cook
P. R. Kongstvedt, M.D.
D. L. Ward

OFFICERS

Chairman:	J. P. Gamble
Executive Vice Chairman:	P. R. Kongstvedt, M.D.
Vice Chairman:	B. W. Giuliani
Secretary:	R. A. Cook
Treasurer:	W. B. Poffenberger
President:	D. L. Ward
Vice President:	M. D. Edwards
	D. B. McIntyre
Assistant Secretary:	J. Petralia

Ownership: 100% The GHMSI Companies, Inc.

Incorporated
Date: May 15, 1987
Where: District of Columbia

Employees: None

Type of Company: Legal

Business: This is a legal entity to offer certain products through CapitalCare.

CAPITALCARE, INC.
Ninth Floor
Tysons International Plaza
1921 Gallows Road
Vienna, Virginia 22182

DIRECTORS

(6 or more Directors)

J. P. Gamble
B. W. Giuliani
S. J. Pace
W. B. Poffenberger
D. H. Kestel
R. A. Cook
P. R. Kongstvedt, M.D.
D. L. Ward

OFFICERS

Chairman:	J. P. Gamble
Executive Vice Chairman:	P. R. Kongstvedt, M.D.
Vice Chairman:	B. W. Giuliani
Secretary:	R. A. Cook
Treasurer:	W. B. Poffenberger
President:	D. L. Ward
Vice President:	M. D. Edwards D. B. McIntyre
Assistant Secretary:	J. Petralia

Ownership: 100% The GHMSI Companies, Inc.

Incorporated
Date: June 22, 1984
Where: District of Columbia

Employees: 285

Type of Company: Operational

Business: CapitalCare, an Individual Practice Association HMO, provides managed care benefits to approximately 100,000 people in the Washington, D. C. metropolitan area. Through comprehensive medical management, a vigorous physician credentialing process, a broad provider network, and a reimbursement program that rewards cost-effective health care, CapitalCare is one of the most effective managed care programs in the local marketplace.

CapitalCare can be offered as a sole carrier or as an alternative carrier to clients who want to provide HMO benefits on a fully-insured or self-insured basis. For businesses that desire a comprehensive and flexible approach to managed care, CapitalCare provides in-network management for both point-of-service and point-of-sale programs.

DUNCAN TRAVEL SERVICES, INC.
t/a TRAVEL CARE
Suite 200A
1825 Eye Street, N.W.
Washington, D. C. 20006

DIRECTORS

S. Edelstein, M.D.
P. McAllister
L. A. Wilson

OFFICERS

Chairman:	S. Edelstein, M.D.
Secretary:	M. O'Doherty
Treasurer:	L. A. Wilson
President:	S. Edelstein, M.D.
Vice President:	P. McAllister

Ownership: 100% World Access, Inc.

Incorporated
Date: January 24, 1989
Where: District of Columbia

Employees: 4

Type of Company: Operational

Business: Corporate travel agency. Arranges travel of enterprise employees and the health care travel of subscribers of World Access, Inc.

EMTRUST, INC.
Suite 725
5845 Richmond Highway
Alexandria, Virginia 22303

DIRECTORS

(6 Directors)

J. P. Gamble
B. W. Giuliani
J. P. O'Brien
J. R. Sielert
J. K. Singleton
D. H. Kestel

OFFICERS

Chairman:	J. K. Singleton
Vice Chairman:	J. P. Gamble
Secretary:	B. W. Giuliani
Treasurer:	J. P. O'Brien

Ownership: 50% Group Hospitalization and Medical Services, Inc.
50% Health Enterprises, Inc.

Incorporated
Date: April 23, 1987
Where: District of Columbia

Employees: 22

Type of Company: Operational

Business: EMTRUST, a joint venture with Inova Health Systems, Northern Virginia's largest medical provider, offers benefits management for self-funded and directed employee benefits programs.

EMTRUST gives customers the flexibility to choose only the services they need in order to help them obtain the most economical pricing. EMTRUST primarily administers benefits for companies between 75 and 1,500 employees. Currently that includes more than 100 clients in the Washington metropolitan area with over 19,000 covered employees.

EMTRUST REINSURANCE COMPANY, INC.
5845 Richmond Highway
Suite 725
Alexandria, Virginia 22303

DIRECTORS	OFFICERS	
(6 Directors)		
J. P. Gamble	Chairman:	J. K. Singleton
B. W. Giuliani	Vice Chairman:	J. P. Gamble
J. P. O'Brien	Secretary:	B. W. Giuliani
J. R. Sielert	Treasurer:	J. P. O'Brien
J. K. Singleton		
D. H. Kestel		

Ownership:	100% EMTRUST, Inc.
Incorporated	
Date:	January 29, 1988
Where:	District of Columbia
Employees:	None
Type of Company:	Operational
Business:	A reinsurance company that takes the risk on EMTRUST products.

FIRST CONTINENTAL LIFE AND
ACCIDENT INSURANCE COMPANY
6925 Union Park Center
Suite 300
P.O. Box 219
Midvale, Utah 84047-0219

DIRECTORS	OFFICERS	
(8 Directors)		
J. P. Gamble	Chairman:	J. P. Gamble
B. W. Giuliani	Vice President:	B. Brundred
D. H. Kestel	President & CEO:	D. H. Kestel
J. H. Waller	Vice President:	G. Brown
K. Deyhle	Secretary:	K. Deyhle
C. Hutton	Assistant Secretary:	B. Brundred
D. Frakes	Treasurer:	R. Dale
R. Dale		

Ownership: 100% Group Hospitalization and Medical Services, Inc.

Incorporated
Date: Acquired April 17, 1992
Where: Midvale, Utah

Employees: 13

Type of Company: Operational

Business: Licensed to offer life insurance products in 43 jurisdictions and markets group life and medical stoploss through a network of over 300 third party administrators.

GHI NOMINEE, INC.
550 12th Street, S.W.
Washington, D. C. 20065

DIRECTORS

(3 to 9 Directors)

J. P. Gamble
B. W. Giuliani
S. J. Pace
W. B. Poffenberger
D. H. Kestel
R. A. Cook

OFFICERS

Chairman and President:	J. P. Gamble
Vice Chairman:	B. W. Giuliani
Secretary:	R. A. Cook
Treasurer:	W. B Poffenberger

Ownership:	100% Group Hospitalization and Medical Services, Inc.
Incorporated Date:	July 28, 1982
Where:	District of Columbia
Employees:	None
Type of Company:	Legal
Business:	Holds title to the land at 550 12th Street, S.W. in the District of Columbia.
	This is a subsidiary established solely to hold title to land at 550 12th Street, S.W. in the District of Columbia. It has no operational or service responsibilities.

THE GHMSI COMPANIES, INC.
550 12th Street, S.W.
Washington, D. C. 20065

DIRECTORS

(3 or more Directors)

J. P. Gamble
B. W. Giuliani
S. J. Pace
W. B. Poffenberger
D. H. Kestel
R. A. Cook

OFFICERS

Chairman:	J. P. Gamble
Vice Chairman:	B. W. Giuliani
Secretary:	R. A. Cook
Treasurer:	W. B. Poffenberger

Ownership: 100% Group Hospitalization and Medical Service, Inc.

Incorporated
Date: December 6, 1985
Where: District of Columbia

Employees: 62

Type of Company: Legal

Business: Holding company

The GHMSI Companies is a legal entity established to hold the stock of GHMSI subsidiaries. In 1988, the role of this subsidiary was expanded to include the corporate staff for payroll and benefit purposes.

GHMSI PARTNERSHIP I
550 12th Street, S.W.
Washington, D. C. 20065

DIRECTORS

(7 Directors)

J. P. Gamble
B. W. Giuliani
W. B. Poffenberger
R. A. Cook
S. J. Pace
D. H. Kestel
P. R. Kongstvedt, M.D.

Ownership:	100% The GHMSI Companies, Inc.
Incorporated Date:	December 9, 1991
Where:	District of Columbia
Employees:	None
Type of Company:	Legal
Business:	Develop, promote, market and sell proprietary data - application systems.

NOTE: There have been no organizational meetings nor are there any bylaws for GHMSI Partnership I to date.

May 31, 1992

GROUP HOSPITALIZATION AND MEDICAL SERVICES INTERNATIONAL, S.A.
* (formerly INTERNATIONAL HEALTH BENEFITS S.A.)
37, Rue Etienne Marcel
Paris, France 75001

DIRECTORS

(3 to 12 Directors)

J. P. Gamble
R. B. Groppe
A. Faignot
R. A. McKenty
C. Dubois
T. Bates
J. Teillard

OFFICERS

Chairman:	C. Dubois
Vice Chairman:	J. P. Gamble
Secretary and Treasurer:	R. B. Groppe
Director General:	A. Faignot
Asst. Treasurer:	S. Howard

Ownership: 100% Group Hospitalization and Medical Services, Inc.

Incorporated
Date: April 25, 1988
Where: Paris, France

Employees: 6

Type of Company: Operational

Business: Authorized in France as a direct non-life insurance company which also provides administrative, management and consulting services to other entities involved with the issuance of insurance and reinsurance policies.

* Name changed January 21, 1991

May 31, 1992

HEALTH MANAGEMENT STRATEGIES INTERNATIONAL, INC.
Suite 300
1725 Duke Street
Alexandria, Virginia 22314

DIRECTORS

(5 or more Directors)

J. P. Gamble
B. W. Giuliani
S. J. Pace
W. B. Poffenberger
D. H. Kestel
R. A. Cook
E. S. Shields

OFFICERS

Chairman:	J. P. Gamble
Vice Chairman:	B. W. Giuliani
Secretary:	R. A. Cook
Treasurer:	W. B. Poffenberger
President:	E. S. Shields
Senior Vice President	A. B. Zients, M.D.
Chief Operating Officer:	W. R. Vandervennet
Vice President:	J. W. Avellar, Ph.D.

Ownership: 100% The GHMSI Companies, Inc.

Incorporated
Date: January 10, 1985 (amended November 19, 1986)
Where: District of Columbia

Employees: 370

Type of Company: Operational

Business: HMS, which was incorporated in 1985, is one of the nation's largest mental health managed care companies, delivering a full range of mental health and medical/surgical management programs. HMS offers its services to over 800 clients representing over 11 million members through the U.S. These services are administered by HMS professional staff of nearly 300 licensed professionals with extensive clinical experience.

HMS is a specialist in managed mental health care services. Its wide range of products works with customers' specific needs. These products include utilization management programs and a Mental Health Provider Network, which provides access to an integrated panel of multidisciplinary providers, including psychiatrists, psychologists, registered nurse clinicians, hospitals and alternative treatment programs.

These programs help provide access to appropriate quality care at reduced costs. Clients save an average of 15 to 30% in health benefit expenses through HMS programs.

May 31, 1992

INTERNATIONAL CLAIMS CENTER E.U.R.L.
37, rue Etienne Marcel
75001 Paris, France

DIRECTORS	OFFICERS
A. Faignot	A. Faignot

Ownership:	100% GHMSI, S.A.
Incorporated Date:	January 1, 1991
Where:	Paris, France
Employees:	None
Type of Company:	Legal
Business:	Captive company of a larger company, set up to provide administrative services. E.U.R.L. distinguishes a company as a limited company, rather than a corporation.

May 31, 1992

INTERNATIONAL CONSULTING SERVICES, INC.
(t/a ICSI Company)
550 12th Street, S.W.
Washington, D. C. 20065

DIRECTORS

(5 or more Directors)

J. P. Gamble
B. W. Giuliani
S. J. Pace
W. B. Poffenberger
D. H. Kestel
R. A. Cook
R. A. Weimer

OFFICERS

Chairman:	J. P. Gamble
Vice Chairman:	B. W. Giuliani
Secretary:	R. A. Cook
Treasurer:	W. B. Poffenberger
President:	R. A. Weimer

Ownership: 100% The GHMSI Companies, Inc.

Incorporated
Date: February 16, 1988
Where: District of Columbia

Employees: None

Type of Company: Service

Business: Provides administrative, management and consulting services to entities involved with the issuance of insurance and reinsurance policies.

ICS is a service company providing actuarial and underwriting services to GHMSI and its subsidiaries such as NCRe, PROTOCOL, IHBI, EMTRUST Reinsurance and other companies within GHMSI and its Insurance Group and International Division, as appropriate. ICS is a break-even company, returning any "profits" to its GHMSI clients at year-end.

INTERNATIONAL HEALTH BENEFITS, INC.
550 12th Street, S.W.
Washington, D. C. 20065

DIRECTORS

(3 or more Directors)

J. P. Gamble
B. W. Giuliani
S. J. Pace
W. B. Poffenberger
D. H. Kestel
R. A. Cook
R. B. Groppe

OFFICERS

Chairman, CEO:	J. P. Gamble
Vice Chairman:	B. W. Giuliani
Secretary:	R. A. Cook
Treasurer:	W. B. Poffenberger
President, COO:	R. B. Groppe

Ownership:	100% The GHMSI Companies, Inc.
Incorporated Date:	October 22, 1985
Where:	District of Columbia
Employees:	16
Type of Company:	Operational
Business:	Provides administrative services for GHMSI health care insurance and benefits in the international market place.

May 31, 1992

INTERNATIONAL HEALTH BENEFITS (IRELAND), LTD.
2 Harbourmaster Place
International Financial Services Centre
Custom House Dock
Dublin, Republic of Ireland

DIRECTORS

J. P. Gamble
R. B. Groppe
D. H. Kestel
D. P. Barrie
D. T. O'Connor
D. T. Reid

OFFICERS

Chairman: J. P. Gamble
Secretary: R. B. Groppe
Treasurer: S. Howard
General Manager: E. J. Phillips

Ownership: 100% Group Hospitalization and Medical Services, Inc.

Incorporated
Date: April 15, 1989
Where: Dublin, Republic of Ireland

Employees: Six

Type of Company: Operational

Business: Operates a Dublin based reinsurance and administrative services company located in the new International Financial Services Centre where a 10% maximum corporate income tax rate is guaranteed through the year 2010. Out of country benefits underwritten by GHMSI are reinsured through this company.

INTERNATIONAL HEALTH BENEFITS, LTD. (Guernsey)
3 College Street, St. Peter Port
Guernsey, Channel Islands

DIRECTORS	OFFICERS	
J. P. Gamble	Chairman:	J. P. Gamble
R. B. Groppe	Secretary:	J. M. Dunning
D. H. Kestel		
J. M. Dunning		
C. Schofield		

Ownership:	100% International Health Benefits, Inc.
Incorporated Date:	January 11, 1989
Where:	Guernsey, Channel Islands
Employees:	None
Type of Company:	Legal
Business:	Operates a Guernsey based holding company in which 50% ownership of International Insurance Associates Limited is held.
	This is a legal entity established to recover commissions on GHMSI business.

INTERNATIONAL INSURANCE ASSOCIATES, LTD.
3 College Street, St. Peter Port
Guernsey, Channel Islands

DIRECTORS	OFFICERS	
J. P. Gamble	Chairman:	J. P. Gamble
R. B. Groppe	Secretary:	J. M. Dunning
J. M. Dunning		
C. Schofield		
D. P. Barrie		

Ownership:	50% International Health Benefits, Ltd. (Guernsey) 50% Fourier Holdings, Ltd.
Incorporated Date:	January 11, 1989
Where:	Guernsey, Channel Islands
Employees:	None
Type of Company:	Legal
Business:	Operates a Guernsey based reinsurance brokerage company through which GHMSI International Division risk is ceded to various reinsurers.

INTERNATIONAL HEALTH BENEFITS OF PANAMA, INC.
550 12th Street, S.W.
Washington, D. C. 20065

Name and Address of Resident Agent:
Sucre y Sucre Abogados
Edificio Sucre y Sucre
Calle 48
Apartado Postal 6277
Panama 5
Republica de Panama

DIRECTORS

J. P. Gamble
B. W. Giuliani
S. J. Pace
W. B. Poffenberger
D. H. Kestel
R. A. Cook
R. B. Groppe

OFFICERS

Chairman:	J. P. Gamble
Vice Chairman:	B. W. Giuliani
Secretary:	R. A. Cook
Treasurer:	W. B. Poffenberger
President:	R. B. Groppe

Ownership: 100% International Health Benefits, Inc.

Incorporated
Date: April 4, 1988
Where: Panama

Employees: None

Type of Company: Legal

Business: Established to meet legal requirements for GHMSI International to do business in Panama through its local partner, Metropolitan de Seguros de Vida.

NATIONAL CAPITAL ADMINISTRATIVE SERVICES, INC.
t/a NATIONAL CLAIMS ADMINISTRATIVE SERVICES, INC.
Suite 200
3702 Pender Drive
Fairfax, Virginia 22030

DIRECTORS

(5 or more Directors)

J. P. Gamble
B. W. Giuliani
S. J. Pace
W. B. Poffenberger
D. H. Kestel
R. A. Cook
W. G. Hendren

OFFICERS

Chairman:	J. P. Gamble
Vice Chairman:	B. W. Giuliani
Secretary:	R. A. Cook
Treasurer:	W. B. Poffenberger
President, CEO:	W. G. Hendren
Vice President:	J. A. Crowley
	D. A. Kreager
	J. S. LeRoy

Ownership: 100% The GHMSI Companies, Inc.

Incorporated
Date: November 3, 1983
Where: District of Columbia

Employees: 140

Type of Company: Operational

Business: Companies who choose to self-fund employees' health benefits programs as plan sponsors use NCAS for administrative support. NCAS maintains a staff of processors and benefit experts to provide assistance with billing, claims processing, customer service, plan documentation, federal filings and data analysis. NCAS also helps companies that want to set up their own administration systems to process their own claims. Currently 122,843 employees across the U.S. are covered through NCAS programs.

NATIONAL CAPITAL INSURANCE AGENCY, INC.
800 9th Street, S.W.
Washington, D. C. 20024

DIRECTORS

(3 to 7 Directors)

J. P. Gamble
B. W. Giuliani
S. J. Pace
W. B. Poffenberger
D. H. Kestel
R. A. Cook

OFFICERS

Chairman:	J. P. Gamble
Vice Chairman:	B. W. Giuliani
Secretary:	R. A. Cook
Treasurer:	W. B. Poffenberger
Assistant Treasurer:	S. K. Webb
President & CEO:	D. H. Kestel
Vice President:	S. E. Homar

Ownership: 100% The GHMSI Companies, Inc.

Incorporated
Date: April 20, 1978
Where: Virginia

Employees: 26

Type of Company: Operational

Business: NCIA is a multi-line agency that offers group life, short and long term disability insurance and dependent life.

In addition, NCIA offers financial planning products for individuals in groups such as payroll deduction universal life insurance, disability income, 401(k) and 403(b) programs. Individuals insurance products to fund key-man insurance, buy-sell agreements and executive compensation plans also are available to meet specific client needs. Currently, NCIA maintains an $8 million book of annualized group life premium in force.

NATIONAL CAPITAL REINSURANCE COMPANY, INC.
Kays House, Suite 205
Roebuck Street
Bridgetown, Barbados

DIRECTORS	OFFICERS	
(4 or more Directors)		
J. P. Gamble	Chairman:	J. P. Gamble
B. W. Giuliani	Vice Chairman:	B. W. Giuliani
S. J. Pace	Secretary:	T. A. Carmichael
W. B. Poffenberger		
R. H. Kestel		
R. A. Cook		
T. A. Carmichael		

Ownership: 100% Group Hospitalization and Medical Services, Inc.

Incorporated
Date: July 6, 1987
Where: Barbados

Employees: None

Type of Company: Operational

Business: Exempt insurance business as permitted under the Barbados Exempt Insurance Act 1983, as amended.

NCRe was established to provide reinsurance coverage to several GHMSI subsidiaries, particularly NCAS, EMTRUST and PROTOCOL. It was established in Barbados to take advantage of favorable laws for reinsurance companies.

NATIONAL CAPITAL REINSURANCE LIMITED
158 Shelbourne Road, Ballsbridge
Dublin 4, Republic of Ireland

DIRECTORS	OFFICERS	
J. P. Gamble	Chairman:	J. P. Gamble
R. B. Groppe	President & CEO:	D. H. Kestel
D. H. Kestel	Vice President:	S. K. Webb
N. Crowley	Secretary:	D. Sweeney
D. T. O'Connor	Treasurer:	D. T. O'Connor
D. T. Reid		

Ownership: 100% The GHMSI Companies, Inc.

Incorporated
Date: January 29, 1991
Where: Dublin, Republic of Ireland

Employees: 1

Type of Company: Operational

Business: NCRe offers individual and aggregate stop-loss insurance to organizations that self-fund their health benefit programs.

NCRe also provides reinsurance to other insurers by assuming a portion of their risk or providing excess loss coverage. Currently, NCRe has over $30 million in annualized reinsurance premium.

NCAS INSURANCE AGENCY, INC.
Suite 200
3702 Pender Drive
Fairfax, Virginia 22030

DIRECTORS

(5 or more Directors)

J. P. Gamble
B. W. Giuliani
S. J. Pace
W. B. Poffenberger
D. H. Kestel
R. A. Cook
W. G. Hendren
C. J. Baker

OFFICERS

Chairman:	J. P. Gamble
Vice Chairman:	B. W. Giuliani
Secretary:	R. A. Cook
Treasurer:	W. B. Poffenberger
President, CEO:	W. G. Hendren

Ownership: 100% National Capital Administrative Services, Inc.

Incorporated
Date: December 8, 1987
Where: District of Columbia

Employees: None

Type of Company: Legal

Business: General insurance agency and brokerage.

A legal entity allowing NCAS to receive commissions on insurance sold to its accounts and franchises.

PROFESSIONAL OFFICE SYSTEMS, INC.
Springfield Office Center
6564 Loisdale Court
Springfield, Virginia 22150

DIRECTORS

(4 or more Directors)

J. P. Gamble
B. W. Giuliani
S. J. Pace
W. B. Poffenberger
D. H. Kestel
R. A. Cook
M. F. Long

OFFICERS

Chairman:	J. P. Gamble
Vice Chairman:	B. W. Giuliani
Secretary:	R. A. Cook
Treasurer:	W. B. Poffenberger
President:	M. F. Long
Vice President:	J. Morrone

Ownership: 100% The GHMSI Companies, Inc.

Incorporated
Date: June 27, 1985
Where: District of Columbia

Employees: 20

Type of Company: Operational

Business: POS offers data processing services, computer hardware and software and office systems advice to physicians, dentists and hospitals.

POS promotes electronic claims filing, which eliminates the need for paper claims. It also conducts seminars to explain how electronic claims filing can reduce paperwork, eliminate errors and speed payments.

PROTOCOL ADMINISTRATIVE SERVICES
8189 Greensboro Drive
Suite 800
McLean, Virginia 22102

DIRECTORS	OFFICERS	
J. P. Gamble	Chairman:	J. P. Gamble
B. W. Giuliani	Vice Chairman:	B. W. Giuliani
H. W. Riley, Jr.	Secretary:	R. A. Cook
S. J. Pace	Treasurer:	W. B. Poffenberger
D. H. Kestel	President:	H. W. Riley, Jr.
R. A. Cook	Vice President:	P. T. Tihansky
W. B. Poffenberger		

Ownership:	100% The GHMSI Companies, Inc.
Incorporated Date:	April 19, 1991
Where:	District of Columbia
Employees:	0
Type of Company:	Legal
Business:	To establish and operate a third party administrator and administrative services organization.

PROTOCOL, INC.
8189 Greensboro Drive
Suite 800
McLean, Virginia 22102

DIRECTORS

(3 or more Directors)

J. P. Gamble
B. W. Giuliani
S. J. Pace
W. B. Poffenberger
D. H. Kestel
R. A. Cook
H. W. Riley, Jr.

OFFICERS

Chairman:	J. P. Gamble
Vice Chairman:	B. W. Giuliani
Secretary:	R. A. Cook
Treasurer:	W. B. Poffenberger
President:	H. W. Riley, Jr.

Ownership: 100% The GHMSI Companies, Inc.

Incorporated
Date: April 22, 1986 (amended May 18, 1988)
Where: District of Columbia

Employees: 57

Type of Company: Operational

Business: PROTOCOL administers customized health care plans for association groups. Through PROTOCOL's affiliation with PPO networks across the U.S., members of association groups gain access to selected health care providers and facilities nationwide.

PROTOCOL also provides access to medical care for the international community -- employees of the diplomatic corps., the foreign service, international organizations and foreign-owned companies -- residing in the U.S. PROTOCOL's network of multilingual health care providers and account representatives specialize in catering to the unique needs of the international community.

WATERLOO INSURANCE BROKERS
1800 King Street South
Waterloo, Ontario N2J1P8

DIRECTORS

M. A. Hogan
D. Mulligan

Ownership:	49% World Access Canada 51% Mike Hogan*
Incorporated	
Date:	October 24, 1991
Where:	Canada
Employees:	1
Type of Company:	Legal
Business:	Brokerage firm which allows World Access Canada to sell insurance on behalf of banks.

* Mike Hogan is the "Designated Individual" under which insurance sales are allowed. This is a requirement to sell insurance in Canada.

May 31, 1992

WORLD ACCESS (ASIA) PTE., LTD.
#11-07 Ocean Building
10 Collyer Quay
Singapore, 0104

DIRECTORS	OFFICERS	
J. P. Gamble	Chairman:	J. P. Gamble
S. Edelstein, M.D.	Vice Chairman:	S. Edelstein, M.D.
P. S. Siah	Secretary:	O. P. Khen
T. J. Keough	Managing Dir.:	P. S. Siah

Ownership: 100% World Access, Inc.

Incorporated
Date: August 22, 1989
Where: Republic of Singapore

Employees: 17

Type of Company: Operational

Business: Provides emergency medical referral and transportation, and 24 hour customer service for large Asian accounts (insurance companies and credit card issuers) and provides support for World Access, Inc., and Access America customers.

WORLD ACCESS AUSTRALASIA PTY. LIMITED
2nd Floor
178 Pacific Highway
St. Leonards NSW 2065
Australia

DIRECTORS

(3 Directors)

J. P. Gamble
S. Edelstein, M.D.
J. Kendall, M.D.

OFFICERS

Chairman:	J. P. Gamble
Vice Chairman:	S. Edelstein, M.D.
Secretary:	T. J. Keough
Managing Dir.:	J. Kendall, M.D.

Ownership: 70% World Access, Inc.
30% John Kendall, M.D.

Incorporated
Date: November 13, 1987
Where: Sydney, Australia

Employees: 60

Type of Company: Operational

Business: Provides emergency medical referral and transportation, and 24 hour customer service to Australian automobile clubs, insurance companies and health funds.

WORLD ACCESS CANADA, INC.
Waterloo Town Square
75 King Street South, Suite 206
Waterloo, Ontario, Canada N2J 1P2

DIRECTORS

(5 Directors)

J. P. Gamble
S. Edelstein, M.D.
D. J. Mulligan
M. A. Hogan
J. R. Donovan

OFFICERS

Chairman:	J. P. Gamble
Vice Chairman:	S. Edelstein, M.D.
President:	D. J. Mulligan

Ownership: 100% World Access, Inc.

Incorporated
Date: January 11, 1988
Where: Canada

Employees: 80

Type of Company: Operational

Business: Provides customer service, marketing, sales, claims administration and assistance services to Canadian banks, insurers and automobile clubs.

WORLD ACCESS HEALTH CARE SERVICES
Suite 200
International Square
1825 Eye Street, N.W.
Washington, D. C. 20006

DIRECTORS

(3 Directors)

S. Edelstein, M.D.
L. A. Wilson
P. McAllister

OFFICERS

Chairman:	S. Edelstein, M.D.
President:	S. Edelstein, M.D.
Vice President:	P. McAllister
Treasurer:	L. A. Wilson
Secretary:	M. O'Doherty

Ownership: 100% World Access, Inc.

Incorporated
Date: April 24, 1989
Where: Delaware

Employees: None

Type of Company: Legal

Business: Recruitment firm established to recruit overseas nurses for placement in U.S. hospitals. The company ceased activities in 1990.

WORLD ACCESS, INC.
Suite 200
International Square
1825 Eye Street, N.W.
Washington, D. C. 20006

DIRECTORS

(9 Directors)

J. P. Gamble
B. W. Giuliani
S. J. Pace
W. B. Poffenberger
A. M. Fox
S. Edelstein, M.D.
R. P. Kaufman, M.D.
R. A. Cook
L. W. MacGregor

OFFICERS

Chairman:	J. P. Gamble
Vice Chairman:	B. W. Giuliani
Secretary:	R. A. Cook
Treasurer:	W. B. Poffenberger
President:	S. Edelstein, M.D
Senior V.P.:	L. A. Wilson
Asst. Secretary:	M. O'Doherty

Ownership: 51% Group Hospitalization and Medical Services, Inc. (acquired July 1, 1983)
49% S. Edelstein, M.D.

Incorporated
Date: May 10, 1982 (amended August 9, 1983)
Where: District of Columbia

Employees: 94

Type of Company: Operational

Business: World Access operates the International Assistance Center, which provides medical assistance for anything from simple referrals to medical emergencies and evacuations. The Assistance Center, located in Washington, D. C., handles over 1,200 calls each business day and is available 24 hours a day via a toll-free hotline. Due to the great diversity of clients and destinations, multilingual coordinators and medical personnel staff the operation center 365 days a year.

To service its customers, World Access maintains a comprehensive international and domestic health care network of hospitals, medical advisors and medical transport firms. A sophisticated communications infrastructure links this extensive global network for immediate action anywhere in the world.

World Access, Inc. also markets retail and group travel services which include assistance for trip interruption, lost baggage, travel accidents as well as a 24-hour hotline for assistance with medical emergencies.

WORLD ACCESS IRELAND, LTD.
#1 Stokes Place
St. Stephens Green
Dublin, Ireland

DIRECTORS

S. Edelstein, M.D.
D. T. O'Connor

Ownership:	100% World Access, Inc.
Incorporated	
Date:	April 16, 1989
Where:	Dublin, Ireland
Employees:	None
Type of Company:	Legal
Business:	Dormant company; formed in anticipation of future business.

WORLD ACCESS LIMITED (UK)
9 Cheapside
London, England

DIRECTORS

Assigned to the 2 incorporating companies: Alnery Incorporations #1 Limited and #2 Limited

OFFICERS

Secretary: Alnery Incorporations #1 Limited

Ownership: 100% World Access, Inc.

Incorporated
Date: May 24, 1989
Where: London, England

Employees: None

Type of Company: Legal

Business: Dormant company; formed in anticipation of future business.

WORLD ACCESS MEDICAL SERVICES

DIRECTORS	OFFICERS
T. J. Keough	Secretary: A. Hirst

Ownership: 100% World Access Australasia

Incorporated
Date: April 1, 1992
Where: Mount Hagen, Papua, New Guinea

Employees: 2

Type of Company: Operational

Business: Clinic that serves expatriates and provides emergency evacuation services to Australian operations.

May 31, 1992

WORLD ACCESS SERVICE CORPORATION
6600 West Board Street
Second Floor
Richmond, Virginia 23230

DIRECTORS

J. P. Gamble
S. Edelstein, M.D.
B. W. Giuliani

OFFICERS

Chairman:	J. P. Gamble
Vice Chairman:	S. Edelstein, M.D.
Secretary:	R. A. Cook
Treasurer:	W. B. Poffenberger
President & CEO:	S. Edelstein, M.D.
Senior Vice President:	L. A. Wilson
	B. Brady
President - Travel:	B. Godlin
President - Financial Markets:	J. Ansell
Vice President:	T. Dwyer
Assistant Secretary:	M. O'Doherty

Ownership:	100% World Access, Inc.
Incorporated Date:	April 20, 1990
Where:	Virginia
Employees:	265
Type of Company:	Service
Business:	Provides customer service, sales and marketing and claims administration services.

GROUP HOSPITALIZATION
AND MEDICAL SERVICES, INC.

MEMORANDUM TO: All GHMSI Employees

FROM: Ben Giuliani Ben Giuliani

SUBJECT: Senate Hearings and News Reports Concerning Blue Cross and Blue Shield Plans

DATE: August 14, 1992

As many of you are aware, the Blue Cross and Blue Shield System has been the subject of some media coverage and a Senate investigation recently. This scrutiny is largely attributable to the insolvency of Blue Cross and Blue Shield of West Virginia in 1990 and recent reports of low cash reserves by some other Blue Cross and Blue Shield Plans. The Senate investigation is ongoing, involves requests for information from a number of Blue Cross and Blue Shield Plans, and will undoubtedly result in additional news stories over the next few months beyond the ones we have already seen. Here are some points to keep in mind about our Plan with regard to this investigation.

Each Blue Cross and Blue Shield Plan is a separate company. As most of you know, the nationwide Blue Cross and Blue Shield organization is made up of 73 locally managed, independent companies. Blue Cross and Blue Shield of the National Capital Area and its parent company, GHMSI, are not connected with the problems some other Blue Cross and Blue Shield organizations may be facing. It is important to stress this fact with customers because many may not understand that each Plan is managed separately.

BCBSNCA and GHMSI are financially sound. BCBSNCA has added to its reserves in each of the last three years, for a total gain of more than $60 million. GHMSI's reserves (which include BCBSNCA's reserves and the reserves of all the subsidiaries) have also shown small gains during this period. Our reserves have been weakened somewhat in 1992 due in part to declining real estate values. Still, both BCBSNCA and GHMSI currently exceed reserve requirements for the jurisdictions in which we operate.

In addition to these reserves, BCBSNCA sets aside claims reserves to pay claims obligations. These claims reserves totalled over $422 million as of June 30, 1992. In sum, we are financially sound, we're meeting all of our financial obligations, and we intend to keep it that way.

Subsidiaries have helped us serve our customers better. Some news reports have mentioned GHMSI's subsidiaries. Our subsidiaries were established for three basic reasons:

- to provide our customers with a broader range of services to meet their employee benefit needs;

- to provide the Enterprise with services that would help us operate more efficiently or otherwise benefit our customers;

- to enhance our financial strength by broadening our base of operations to give us other sources of operating gains besides our regular health insurance business.

With respect to the first two goals, our subsidiaries have been successful. They have enabled us to better serve our customers, and, thereby, attract and retain customers who otherwise would have chosen our competitors. For example, CapitalCare has allowed us to become a local leader in providing managed care programs. Health Management Strategies International, Inc. has helped contain our customers' claims costs while assuring that they receive appropriate care. National Capital Life Insurance Agency has enabled customers to get life, disability, and other types of insurance together with their health benefits -- a service our commercial competitors routinely provide. National Capital Administrative Services, Inc. has enabled us to retain or gain customers in the metropolitan area in cases where the customer desired third party administration capabilities. Professional Office Systems, Inc. helps us operate more efficiently as does our subsidiary in West Virginia, Capital Area Services Company, Inc.

In addition to better serving our customers, we believed that broadening our base of operations would add to our financial stability. For the past 25 years, health insurers in the U.S. have experienced periodic cycles of gains and losses. Subsidiaries were intended to cushion us from these cycles by giving us other sources of operating gains that were not subject to the cycles. In this goal, the results have been mixed. Nearly all of the subsidiaries have grown in business volume and revenue; about 20% of our corporate revenue now comes from operations other than local Blue Cross and Blue Shield business. While some subsidiaries have been profitable, the financial results of the subsidiaries as a group have been less than we had anticipated and losses have occurred. Indeed, well prior to the recent publicity and Congressional interest, we undertook an extensive evaluation of our business units' operations, and when that review is finalized, if not before, it will assist us in taking whatever measures may be required to improve our overall results.

We are cooperating with the Senate's requests for information. As the Senate continues to investigate the Blue Cross and Blue Shield System, we will cooperate fully. We know that over 1.1 million people in the Washington metropolitan area depend on us to provide them with high quality health insurance and we take this responsibility very seriously. We will do everything we can to address the concerns of the Subcommittee so that our customers and the public will continue to have confidence in our company. Through our legal counsel, we are in close communication with the Subcommittee and are working diligently to meet the Subcommittee's needs.

We are also committed to maintaining a good work environment where you, as employees, can continue to be proud of your work and your company. We face many challenges over the next year. But with your continued support and dedication, we can and will meet these challenges and I believe we will be a stronger company because of them.

Attached are answers to common questions you or our customers may have about the investigation. If you need additional information or help in answering more detailed questions, please contact Public Relations and Advertising at 479-8302.

Questions and Answers: Senate Investigation and Media Coverage of the BCBS System

1. I have heard news recently of some trouble at Blue Cross and Blue Shield. What's that all about?

The Blue Cross and Blue Shield System has been the subject of some media coverage and a Senate investigation recently. This scrutiny is largely attributable to the failure of Blue Cross and Blue Shield of West Virginia in 1990 and recent reports of low cash reserves by some other Plans in the Blue Cross and Blue Shield System.

Many people assume that Blue Cross and Blue Shield is a single nationwide company. In reality, we are a system of 73 locally managed, independent companies that must meet certain standards in order to use the Blue Cross and Blue Shield names -- like a franchise. Each company's finances and management practices are separate and each company must be judged on its own merits.

Here in the Washington area, Blue Cross and Blue Shield of the National Capital Area is in sound financial shape and we are in no way connected with the problems some other Blue Cross and Blue Shield companies may be facing. We have added to our reserves over the past three years and we currently exceed the reserve requirements for all three jurisdictions in which we serve customers.

2. Does any of this news mean that my coverage could be in trouble?

No. We are in sound financial shape, we have the cash reserves we need to pay your claims when you file them, and we intend to keep it that way.

3. You say you're financially stable, but what would happen if you did run out of money? What are these guarantee funds mentioned in the news reports, and would they cover my claims?

We participate in guarantee funds in Maryland, Virginia, and the District of Columbia. These funds would cover our customers up to specified limits: for D. C. residents, up to $100,000 per participant; for Virginia residents, up to $300,000 per participant; and for Maryland residents, up to the contractual limits of the subscriber's policy.

4. Who regulates you?

We report to and comply with the insurance departments in both Maryland and Virginia. We also voluntarily file all the same insurance forms with the D. C. Department of Insurance and we maintain regular contact with the Department's staff. In effect, we are double regulated, with some additional oversight from the District.

Both Maryland and Virginia conduct periodic audits of our operations. We are currently undergoing our regular triennial review by the Virginia Insurance Department.

5. Why does GHMSI have so many subsidiaries?

GHMSI's subsidiaries were created for three reasons: to expand the scope of products and services we offer our customers, to support BCBSNCA's operations, and to provide operating gains to help level out the cycles of gains and losses we experience in underwriting health insurance coverage. We currently have eight basic lines of business (which correspond to the eight GHMSI divisions). Within these

divisions, there are a total of 45 subsidiaries; however, nearly half were formed either for legal reasons or as cost centers that enable us to allocate costs or revenue more accurately. Twenty-five are classified as operating companies that provide products or services to external customers.

6. Have Blue Cross and Blue Shield subscribers had to pay more for coverage because of GHMSI's diversification?

No. GHMSI's investments in subsidiaries have come from reserve funds. BCBSNCA rates have risen because of increases in the cost and use of health care services. We have not marked up the cost of health coverage to our customers to pay for diversification activities. Overall, for every dollar we receive in premiums, only 8.2 cents are spent on administrative costs. That's less than the average for all Blue Cross and Blue Shield Plans and about half what our commercial insurance competitors spend.

7. What are reserves and what are they used for?

Reserves, also called our "surplus" or "net worth," is the difference between our assets (what we have) and our liabilities (what we owe). Reserves are kept as a cushion to be used in years when we must pay out more in claims and operating costs than we receive in premiums. Reserves can also be used to fund major activities with long-term benefits to our customers -- such as a new computer system or start-up costs for new programs.

Our reserves stood at $102 million at the end of 1991. These reserves have been reduced somewhat in 1992, due in part to declining real estate values. However, our reserves still exceed all the requirements for the jurisdictions in which we operate. In addition to these reserves, we hold "claims reserves" to cover claims expenses that have been incurred, but for which we have not yet received or processed claims. As of June, 1992, our claims reserves totalled $422 million. Moreover, the federal government holds $1.9 billion in additional reserves for the Federal Employee Program, which constitutes about 40% of our subscribers.

8. A recent article in The Washington Post *noted that you had a net income of $16.3 million according to your 1991 insurance filing, but a $7.2 million loss according to your audited financial statements. Which number is correct?*

Both numbers are correct. Our financial statements are prepared using two different sets of accounting principles, one using Statutory Accounting Principles (SAP) and the other using Generally Accepted Accounting Principles (GAAP). SAP is the accounting method required by insurance departments for reporting purposes. GAAP is a common business method used by our external auditors to prepare our annual reports. Our financial results are calculated using both methods, and both reports are audited. In this case, $7.2 million is GHMSI's net loss from operations as calculated using GAAP and this reflects the operating results of BCBSNCA and all subsidiaries in 1991. The $16.3 million gain reported under SAP is basically the operating results of BCBSNCA only in 1991 adjusted for a pension expense which is recorded under GAAP but not under SAP.

9. What is BCBSNCA doing to respond to the Senate investigation? What will happen next?

The Senate Subcommittee held its first hearing in early July. At that hearing, insurance commissioners from Maryland and the District of Columbia testified about a number of regulatory issues. This was followed by two hearings at the end of July into the failure of the West Virginia Plan. Beginning in

September, more hearings are planned, potentially involving a number of Blue Cross and Blue Shield Plans. While GHMSI may be the subject of one of them, we are advised that the Subcommittee may not hold a hearing with regard to GHMSI. The Subcommittee, however, has requested a variety of information from us.

Shortly after the first hearing, a task force of senior management was appointed to coordinate our response to the Senate's request for information and special outside legal counsel to represent GHMSI and its companies was retained. The firm's legislative affairs experts have had an initial meeting with the Senate Subcommittee staff in which a cooperative tone was achieved, the information was narrowed, and a reasonable schedule for production was agreed upon.

GROUP HOSPITALIZATION
AND MEDICAL SERVICES, INC.

MEMORANDUM TO: GHMSI Board of Trustees

FROM: J. P. Gamble

DATE: October 23, 1992

Since July 21, 1992 when I decided to announce my retirement, I have been careful to avoid reacting to any decisions being made which could be construed as not supporting Ben Giuliani during the transition. I have assured Ben that I am here to assist him in the many things which need to be done, and not to become involved in those decisions and changes which he feels are necessary.

In a recent conversation with Peter O'Malley, he encouraged me to speak out on issues that I feel are important, and I have chosen to do so on the proposed transfer of control of GHMSI to Blue Cross and Blue Shield of Virginia (BCBSV). I hope I can do so without suggesting a decision, but rather suggesting a point of view regarding the process.

As Peter has pointed out, I initiated an effort in the early 1980's to create a Mid-Atlantic Service Corporation (Big-MAC) of Plans, and we spent considerable effort in trying to bring that about. It is suggested that the takeover by BCBSV would move us in that same direction. I would suggest, however, that Big-MAC was designed to be a joint effort that would be mutually beneficial to the subscribers of the Plans involved.

The Big-MAC initiative was brought about, in part, by my increasing concerns that the Blue Cross and Blue Shield system had some long-term problems which were not being addressed due to the unwillingness of chief executive officers (CEO's) to work together in a way which would be beneficial to our subscribers.

With that regionalization strategy unavailable, greater focus was placed on a diversification strategy. It was thought that through diversification, we could build an organization that was not reliant on BCBSNCA for its financial strength and one which could, in fact, support BCBSNCA. Significant strides have been made to the point that 20% of GHMSI's 1991 revenues came from subsidiaries. I recognize that our financial results in the last few years include several losses which were attributable to poor actuarial work, but those problems were not systemic and are solvable. Therefore, the outlook for the

future should be one of greater success for the diversification strategy with modifications which are determined to be appropriate and a movement toward greater financial strength for GHMSI.

With the above as background, it seems to me that the GHMSI trustees need to know precisely what the problems are and what are the alternatives available to the board to deal with the problems. For example, if the Virginia Insurance Department requires up to 45 days of risk claims in reserve, what is that amount, what reserves do we have, would he accept less than 45 days and on what conditions, and what can he legally do if we fall below the required level. Also, what steps can we take to correct the problem. Similarly, what is the BCBSA standard for liquidity, do we meet that standard, can we challenge BCBSA to provide us with the liquidity to meet the requirement for the Federal Employee Program (FEP), can we challenge their failure to correct a flawed formula, and what can they legally do if we do not meet the standard. Also, what steps can we take, such as repatriation of several million dollars from Ireland that will correct the problem.

The trustees should evaluate the threat of BCBSA to delicense the Plan and on what basis can that legally be done. It should be pointed out that 75% of the CEO's need to approve such an action, raising the question of whether doing that in the Nation's Capital would be a risk to the image of the system that 75% of the CEO's would take against a Plan which had $102 million in statutory reserves less than 10 months ago. Would a "recovery" plan of Ben's be rejected by such a large percentage of his peers?

It seems to me that in evaluating the BCBSV proposal, the trustees should clearly know how much capital, if any, is needed by GHMSI to avoid a takeover. Also, the trustees should address the question of whether a takeover, if needed, can be structured so as to protect the interests of our subscribers in the Nation's Capital and Jamaica, and the clients of GHMSI in the United States and worldwide. Will our commitments be honored, and will the assets of GHMSI be protected if they are not?

Consideration should also be given to whether there are values and assets, such as CapitalCare, which are not reflected on the financial statements which could be lost to our subscribers and transferred to Richmond in a takeover. If that happens, is there any liability on the part of GHMSI trustees?

Finally, if a takeover is to be approved, it should be based upon good and compelling reasons, and not to simply satisfy the concerns of outsiders.

I hope my comments contribute to a thoughtful and thorough consideration of the issues, and help to produce a decision which is appropriate given the problems which are identified.

cc: Benjamin W. Giuliani
George W. Jones, M.D.
Floretta D. McKenzie, Ph.D.
John E. Sumter, Jr.

GROUP HOSPITALIZATION, INC.

Minutes of the
Meeting of the Board of Trustees
Held in the Offices of GHI
Washington, D. C.
May 20, 1983

PRESENT

Trustees:	James E. Boland, M.D.	LaSalle D. Leffall, Jr., M.D.
	Charlotte G. Chapman	Delano E. Lewis
	Charles P. Duvall, M.D.	Robert E. Petersen
	Ralph W. Frey	David M. Seitzman, M.D.
	Thomas R. Harrison	Leo W. Zajac
Staff:	J. P. Gamble	R. A. Cook
	B. W. Giuliani	
Counsel:	Charles J. Steele	
Other:	Jack Kleh, M.D.	

ABSENT

Trustees:	Wilfred L. Goodwyn	Matthew F. McNulty, Jr., Sc.D.
	Robert W. Langevin, M.D.	Lutrelle F. Parker
	Anna B. J. Marsh	

Mr. Harrison, chairman, called the meeting to order at 12:25 p.m.

Mr. Giuliani, secretary, reported that a copy of the call of the meeting had been mailed to each trustee and that a quorum was present, whereupon the Chairman stated that it was in order to proceed with the business of the meeting.

MINUTES OF THE ANNUAL BOARD MEETING - MARCH 25, 1983

The Chairman stated that copies of the minutes of the annual board meeting of March 25, 1983 had been mailed to and noted by the trustees. There being no corrections, it was

VOTED: To approve the minutes of the annual board meeting of March 25, 1983 as circulated and presented.

MINUTES OF THE GHI AD HOC COMMITTEE ON GHI AND MSDC RELATIONS - APRIL 19, 1983

The Chairman stated that copies of the minutes of the meeting of the GHI Ad Hoc Committee on GHI and MSDC Relations of April 19, 1983 had been mailed

to and noted by the Committee members. He said the minutes were included with the tentative agenda material for the remaining trustees. There being no corrections, it was

VOTED: To accept the minutes of the April 19, 1983 meeting of the GHI Ad Hoc Committee on GHI and MSDC Relations as circulated and presented.

MINUTES OF THE MEETING OF THE COMMITTEE ON FINANCE AND INVESTMENT - MAY 4, 1983

The Chairman stated that copies of the minutes of the meeting of the Committee on Finance and Investment of May 4, 1983 had been mailed to and noted by the Committee members. He said the minutes were included with the tentative agenda material for the remaining trustees. There being no corrections, it was

VOTED: To accept the minutes of the May 4, 1983 meeting of the Committee on Finance and Investment as circulated and presented.

FINANCIAL STATEMENTS - APRIL 30, 1983

Mr. Giuliani presented the financial statements as of April 30, 1983, copies of which were not available to be mailed to the trustees with the tentative agenda material, but were distributed at the meeting.

The Comparative Balance Sheet showed that assets had increased $33,881,150.40 from assets of a year ago, during which time liabilities increased $19,619,210.63, and reserves increased $14,261,939.77. Mr. Giuliani also commented upon several items which contributed to substantial changes in assets and liabilities from April 30, 1982 to April 30, 1983, and explained that of the $14 million reserve addition over the past year, $11.4 million was as a result of other income, primarily investment income.

The Comparative Statement of Earned Income and Incurred Expense indicated that earned subscription charges during the first four months of 1983 were $138,779,616.90, a decrease of $1,581,252.98 from the like 1982 period, while incurred expenses decreased $2,695,438.01 to $137,557,108.28. This resulted in a gain of $1,222,508.62 from underwriting during the first four months of 1983, which represented an improvement of $1,114,185.03 over the like 1982 period. Including other income and expense, the total excess of income over expense for the first four months of 1983 was $5,807,362.73, an increase of $4,097,784.66 from the like 1982 period.

Following a discussion, it was

VOTED: To accept the financial statements dated April 30, 1983.

PRESIDENT'S REPORT

Mr. Gamble reviewed his report, copies of which had been mailed to the trustees.

Enrollment

Mr. Gamble reviewed the March 31 enrollment data for 1983, 1982 and 1981.

Price Waterhouse Management Letter

Mr. Gamble stated that Price Waterhouse, outside auditors for GHI, had submitted a management letter in which they stated that no condition had been disclosed that they believed to be a material weakness.

Age Rating of Groups with 10-49 Subscribers

Mr. Gamble reported that GHI and Medical Service of D. C. (MSDC) had always charged the same rate for the same benefit for all accounts with less than 50 employees, regardless of each account's actual claims experience. He said, however, that in recent years, more and more competitors had begun to age rate accounts of less than 50 subscribers. He explained that age rating resulted in accounts with an average younger age paying less than accounts with an average older age. He said that as a result, GHI and MSDC rates were not competitive for younger accounts, and were more than competitive for older accounts, which resulted in GHI and MSDC usually enrolling accounts with a higher than average age, and not enrolling those with a younger than average age.

Mr. Gamble stated that to correct this situation, GHI and MSDC would begin to age rate accounts with 10-49 subscribers effective with rate changes on and after September 1, 1983. He said that while this might cause an increase in rates for older age groups, it would moderate the increase or cause rate decreases for younger age groups. He said that it should also enable GHI and MSDC to become more competitive among all accounts of this size.

Merger Activities

Mr. Gamble said that the subject of the merger of GHI and MSDC had been discussed briefly at the GHI Board Seminar in late April and more recently at a MSDC Executive Committee Planning Seminar in early May. He reported

that the MSDC Executive Committee had voted to recommend to the MSDC Board that the Committee be designated to serve as a negotiating committee, and that Mr. Brian be given authority to proceed in his discussions with GHI staff and the consulting firm of Booz, Allen & Hamilton. Mr. Gamble said that the recommendation of the MSDC Executive Committee would be considered by the MSDC Board at its meeting on May 24, 1983.

Mid-Atlantic Council

Mr. Gamble reported that the Mid-Atlantic Council of Blue Cross and Blue Shield Plan Presidents had met on April 26, 1983 with representatives of Booz, Allen & Hamilton to further pursue the concept of a consolidation of Plans in the region. He stated that the next meeting of the group has been scheduled for June 13, 1983. He said that the basic concept being explored was to have the member Plans retain their local structures with a "holding company" being created to provide overall guidance to the member Plans, and to serve as the focal point for appropriate consolidation of efforts or diversification.

Virginia Service Area

Mr. Gamble stated that as he had reported to the board at its meeting on March 25, 1983, there would no longer be any territorial areas assigned to Blue Cross and Blue Shield Plans operating in Virginia on and after July 1, 1983. He said that GHI and MSDC employees have been informed by staff that, on that date, GHI and MSDC would adopt as the Plans' service area in Virginia an area including all of Fairfax County, as well as Arlington County and the cities of Alexandria and Fairfax. He stated that this was basically the same as GHI and MSDC's existing service area except for the western fringe of Fairfax County. Mr. Gamble stated that staff has also indicated that GHI might contract with facilities located in Prince William and Loudoun counties for the care of GHI subscribers, if the facility and GHI determine it is appropriate and advantageous to do so.

Mr. Gamble then advised the trustees of a filing by the Blue Cross and Blue Shield Plan of Richmond, Virginia with the D. C. Recorder of Deeds to incorporate seven organizations in the District of Columbia whose names include the term "Blue Cross and Blue Shield". He explained that the National Association had obtained a temporary restraining order which prevented the D. C. Recorder of Deeds from approving this filing. He added that a court hearing on the Association's motion for a preliminary injunction had been postponed until June 8, 1983.

D. C. School Project

Mr. Gamble reported that this year the D. C. school system, in partnership with area businesses and industry, had installed five new career programs in D. C. high schools. He said that GHI, Medical Service of D. C. and the D. C. Bankers Association were sponsoring the Business and Finance Program

at Woodson Senior High School. Mr. Gamble explained that the goals of this Program were to (1) better prepare students who sought employment upon graduation or who planned to pursue a higher degree in business, (2) establish a strong linkage between schools and businesses, and (3) develop and implement on-going school staff development.

He stated that GHI and MSDC staff had assisted curriculum planners in establishing position requirements and related job skills for the Program, had conducted on-site data processing orientations and had presented workshops on career counseling, employment interview and job application techniques, and marketing careers.

Mr. Gamble stated that GHI and MSDC have been requested to consider additional involvement in the Program by assisting with the refinement of specialized curriculum at the 11th and 12th grade levels; providing guest lecturers/seminar leaders, as well as field trips and special on-site workshops; offering internship experiences for students, teachers and administrators, and workstudy slots for senior students; assisting with the establishment of a mentor program; and providing scholarship awards to outstanding students, as well as a financial contribution to the Future Business Leaders of America Club. He said that staff believed this to be a worthwhile community endeavor and staff was currently evaluating the request for additional efforts in the Program.

U. S. International Cultural and Trade Center

Mr. Gamble said he thought it might be of general interest to the board to know that the Federal City Council has embarked on a project designed to lead to the creation of an International Center immediately south and east of the GHI Building. He then referred to the two exhibits attached to the report which identified the area where the Center would be located. He stated that also to be included was a fifty-acre tract of East Potomac Park.

Mr. Gamble explained that the Center would include five components, consisting of an exhibition area, a trade center, an education center, an international bazaar, and a sports and athletic events area. He said that the principal area would consist of 2.3 million square feet of building and parking space to be financed through a public development corporation issuing tax-exempt bonds.

Mr. Gamble said that the objectives were to provide an appropriate focus and showcase for the Washington international community; to encourage greater international trade and cultural exchange; to enhance the Southwest waterfront area as an attraction for both tourists and area residents; and to create additional local employment and business opportunities.

Mr. Gamble explained that as a member of the Council, he was serving as a member of the International Center Committee, and had expressed the support of GHI, as a Southwest business organization, for the project.

In response to a question, Mr. Gamble explained that ownership of the project would eventually revert to the U. S. Government.

Following a discussion, it was

VOTED: To accept the President's Report dated May 20, 1983.

LEGAL COUNSEL'S REPORT

Mr. Steele reviewed his report, copies of which had been mailed to the trustees.

Ratino v. MSDC

Mr. Steele reported that there had been no change in this case since his last report.

Federal Trade Commission Investigation

Mr. Steele reported that there had been no change in this case since his last report.

Goss v. GHI and MSDC

Mr. Steele said that this case, which involved the issue of whether the second stage of treatment for tempero mandibular joint syndrome was medical or dental, had been argued before the District of Columbia Court of Appeals on April 5, 1983. He reported that no decision had been made by the Court.

American Health Services, Inc. v. GHI, et al.

Mr. Steele stated that this case, which involved the question of whether a non-participating hospital was a third-party beneficiary of contracts between GHI and its subscribers, was still pending in the United States District Court for the District of Maryland, where GHI had moved for summary judgment.

D. C. Institute of Mental Hygiene v. GHI and MSDC

Mr. Steele reported that this case, which involved the conflict between the District of Columbia Mental Health Records Act and the federal statute which had established the Government-wide Service Benefit Plan administered by Blue Cross and Blue Shield Plans, was pending before the District of Columbia Court of Appeals. He stated that the Court below had ruled in favor of GHI and MSDC. He said that the D. C. Institute of Mental Hygiene had filed its brief and the appellees' brief was being prepared.

Loretta Washington v. GHI and MSDC; Smith v. GHI and MSDC; Senkowski v. GHI and MSDC; Old World Gourmet v. GHI and MSDC

Mr. Steele stated that these and other "outrage" or alleged breached fiduciary duty cases were all awaiting trial and were in the discovery stage.

Virginia Association of Life Underwriters v. GHI, MSDC and National Capital Insurance Agency

Mr. Steele stated that there had been no change in this case since his last report.

Virginia Service Area

He said that there had been no change in this case since his last report.

Hypertension Center of Washington v. MSDC

Mr. Steele advised the trustees that there had been no change in this case since his last report.

Following a discussion, it was

VOTED: To accept the Legal Counsel's Report dated May 20, 1983.

PROPOSAL TO ACQUIRE A MAJORITY INTEREST IN WORLD ACCESS, INC.

The Chairman asked Mr. Gamble to present a report entitled "Proposal to Acquire a Majority Interest in World Access, Inc." dated May 20, 1983, copies of which had been mailed to the trustees.

Mr. Gamble said that this decade would present GHI with many new challenges and opportunities. He stated that the Company's success would depend not only on GHI's ability to compete with commercial health insurance carriers, but on GHI's ability to diversify into new markets which would benefit GHI's subscribers.

Mr. Gamble stated that diversification should recognize the major strengths of GHI and translate them into market strategy. He said that the objective of this strategy should be to protect the long-term financial viability of the Corporation. He explained that the health insurance market, which is GHI's primary market, is unpredictable, yet highly competitive. Mr. Gamble said that the market with its present cost trends did not offer GHI the certainty of long-term financial viability. He stated that GHI needed to identify and develop new markets and new products which would help stabilize the Company's long-term financial future. He said that this

would allow the Corporation to realize a return on its investment in such activities, and, at the same time, enhance GHI's service to subscribers.

Mr. Gamble said that in analyzing potential new markets, the international market in Washington had quickly come to the forefront. He explained that this market existed in several segments:

1. Private U. S. corporations whose employees were either traveling abroad, or were residing abroad for their business responsibilities

2. Federal agencies whose employees were traveling or residing abroad

3. Federal contractors whose employees were traveling abroad for the government

4. Trade, cultural and economic delegations traveling abroad as representatives of the U. S.

5. The entire embassy community and all their related programs -- students, military attachés, etc.

6. U. S. tourists traveling abroad

Mr. Gamble stated that with such a market potential, the issue for GHI became how to develop products which met a particular need of that market. He said that staff had been analyzing several possible products for this market, including various types of travel health insurance.

Mr. Gamble stated that staff had recently had discussions with representatives of George Washington University (GWU), which had become the agent in the United States for a French organization known as EUROP Assistance. He explained that the University's role was to coordinate the delivery of emergency medical services and evacuation for EUROP Assistance's members in need of such services while in the United States. He said that this was accomplished in coordination with the U. S. office of EUROP Assistance located in Washington, D. C. Mr. Gamble stated that these conversations had led to further discussions, most having occurred in the past several weeks, with a physician member of the GWU team who had created an organization known as World Access, Inc. (WAI) to interact with the D. C. office of EUROP Assistance for the purpose of marketing the EUROP Assistance product in the United States. Mr. Gamble explained that WAI is essentially a comprehensive medical travel assistance service plan, corporately headquartered in Washington, D. C. He said that it was the intent of WAI to provide a broad scope of medical travel assistance to the U. S. traveler abroad, as well as to foreign nationals traveling in the United States.

Mr. Gamble explained that WAI had been designed to interact with EUROP Assistance to provide medical advice, intervention, and, if necessary, repatriation services as follows:

1. Medical advice to travelers abroad

2. Should the traveler incur a significant health problem abroad, WAI or EUROP Assistance physicians would become actively involved in determining levels and type of care required.

3. Should emergency hospitalization be required or a severe medical emergency occur, WAI or EUROP Assistance would monitor and evaluate the overseas medical delivery system and determine if the patient was in the most appropriate facility. WAI or EUROP Assistance would coordinate activities with the patient's private physician.

4. Should transfer or repatriation be required, WAI or EUROP Assistance would coordinate these services as well.

5. WAI would also supply additional services such as supplemental insurance, payment guarantees, repatriation of deceased travelers, and possibly services such as bail bond services and legal assistance.

He stated that it was the intention of WAI to develop an operations center that would be the focal point of its delivery program. Mr. Gamble advised the trustees that this center would serve as a 24-hour emergency assistance center. He said that any WAI subscriber would have telephone or telex access to the center. He said that the center would be staffed by multi-lingual medical or paramedical specialists. Mr. Gamble added that the center would offer emergency physician telephone advice and intervention if a subscriber incurred a serious medical problem. He said that WAI physicians would evaluate and monitor care. He explained that if necessary, these physicians could arrange for transfer and repatriation services through contracts which WAI would have with EUROP Assistance. Mr. Gamble stated that recognizing that there might be parts of the world where EUROP Assistance did not have the desired capabilities, WAI had concluded that it should also contract with other established international travel assistance providers, such as Swiss Air Ambulance, Assist-Card International and GESA Assistance. He commented that WAI would also contract with several prestigious trauma medical centers strategically located in the United States. He explained that these centers would be able to provide medical escorts and transportation for WAI subscribers in those parts of the world not covered by the established travel assistance

providers. Mr. Gamble stated that in addition, WAI would arrange for a ready reserve of emergency physicians and nurses to handle repatriation if a major emergency occurred.

He said that as presently envisioned, WAI would provide full-service packages, limited-service packages, or incident packages. Mr. Gamble explained that in the first, the corporate subscriber would pay a fee which entitled the subscriber to all covered services. Mr. Gamble stated that a limited-service contract allowed the client to pay a fee for access to WAI services, which would be billed on a cost-basis if the client used them. He added that the incident package would allow certain clients to contract with WAI to handle a specific medical problem for its employees. He said that in this case, the client would pay WAI's cost, plus a reasonable fee.

Mr. Gamble stated that WAI was currently in the developmental stage. He explained that it anticipated opening its operations center in the fall of 1983. He said that for the next year or so, WAI would go through an extensive shake-down process, which would include the initial marketing operation. He added that after this period, WAI would expect to be entering a mature market stage. Mr. Gamble advised the trustees that the final phase of development could call for WAI developing its own international network.

Mr. Gamble stated that in staff's discussions with World Access, Inc., it had become apparent that a relationship between GHI and WAI would enable GHI to achieve several objectives:

- The product could be marketed to GHI's existing and prospective accounts.
- The product would compliment GHI's existing health insurance marketing strategies. Existing GHI staff could be used to actively market the program.
- GHI could have an exclusive arrangement with World Access, Inc. to market this product in the United States, which would allow GHI to offer the product to the entire Blue Cross and Blue Shield system.
- GHI would have the potential to earn a return on its investment for the benefit of subscribers.

Mr. Gamble stated that with these objectives in mind, staff had had several negotiating sessions with the owner of WAI, which resulted in an agreement being reached whereby GHI would acquire the majority interest (51%) of World Access, Inc. in return for a capital investment and GHI's organizational capabilities. He said that the existing owner of WAI, a physician currently managing the GWU relationship with EUROP Assistance,

would retain a minority interest (49%) of WAI in return for the expertise he would bring to the organization. Mr. Gamble said that also, the existing owner would become the chief executive officer of WAI to manage and direct the activities of the company. Mr. Gamble noted that there was currently one other shareholder who had a 5% interest in WAI who would retain a proportionate share of the new minority interest in WAI.

Mr. Gamble stated that under the arrangement, GHI would provide World Access, Inc. with $500,000 initial capital to provide for operational expenses during the initial stages of its operations. He said that subsequent capital outlays might be needed to support operations until sufficient income from sales was generated to produce operating gains. He reported that first-year expenses were projected to be $800,000, while first-year revenues were difficult to project at this stage. Mr. Gamble said that in return for its capital investment, GHI would become the majority shareholder of World Access, Inc., and would have the authority to select and appoint a majority of the board of directors of World Access, Inc. He said that under the arrangement, the current owner of World Access, Inc. would become the minority shareholder of the company, with the authority to appoint a minority of the board of directors.

Mr. Gamble explained that GHI's stock would be the capital stock of the company, and recoupment of capital would be required before surplus would accrue to the benefit of any shareholder. He said that staff believed the subsequent sharing of surplus would provide the management of the organization, the minority shareholder, with an appropriate incentive to have it succeed. He added that this would include a stock redemption arrangement for the future.

Mr. Gamble stated that there has been little experience in this country with medical travel assistance. He said, however, that there has been considerable experience in other parts of the world. He informed the trustees that the Ontario Blue Cross Plan had successfully marketed a for-profit medical assistance package to Canadians traveling abroad. He added that in Europe, firms such as EUROP Assistance, Swiss Air Ambulance, Assist-Card International, etc., have successfully marketed medical travel assistance programs to European corporations as well as tourists. Mr. Gamble stated that their enrollment numbered in the millions. He said that staff believed this represented a unique opportunity for GHI to enter the marketplace with an attractive product, and to do so in a way that could be beneficial to GHI's subscribers.

Mr. Gamble stated, therefore, that staff recommended that it be authorized to negotiate an arrangement with World Access, Inc. along the lines set forth above. He said that since GHI staff has not had the opportunity to explore with Medical Service of D. C. their interest in sharing in this program, staff would recommend that they be offered the opportunity to do so, if they wish.

Mr. Gamble explained that he had just received a preliminary actuarial projection through 1987 from the firm of Deloitte Haskins & Sells and that it was concurrently under review.

A lengthy discussion followed regarding the marketing opportunities this would provide GHI with prospective accounts, the volume of annual overseas travel by U. S. citizens and the present competition. Mr. Gamble also responded to questions concerning the difficulty of projecting the first year's revenue, the support services that would be purchased from GHI, the components of the minority stock ownership and of the amount of venture capital being provided by GHI.

It was then

VOTED: To authorize staff to negotiate an arrangement with World Access, Inc. along the lines set forth in the staff proposal.

It was also agreed that Medical Service of D. C. should be offered the opportunity to share in this program with GHI, if they wished to do so.

OTHER BUSINESS

Mr. Gamble informed the trustees that in an effort to open lines of communication, GHI staff would host a luncheon for members of the D. C. City Council and a member of each of their staffs on Wednesday, June 1, 1983.

Mr. Gamble stated that an issue between GHI and Providence Hospital involving the extent to which investment earnings on the Hospital's funded depreciation portfolio should be used to reduce the Hospital's costs has not been resolved to the Hospital's satisfaction. He said that the Hospital plans to proceed with legal action in an attempt to resolve the dispute, which results from different interpretations of a provision in the Hospital Cost Manual. Mr. Gamble explained that this issue had been considered by the Provider Relations Committee and by the board, and that staff had attempted to resolve the issue, but an impasse had been reached. He stated that GHI has applied this policy consistently among all hospitals since 1962, the effective date of the Hospital Cost Manual.

Mr. Gamble reminded the trustees who had incurred out-of-pocket expenses as a result of the Board Seminar at The Homestead and had not submitted an expense report, to do so at their earliest convenience. Mr. Harrison expressed his appreciation for the staff efforts during the recent Board Seminar which he felt was outstanding.

Mr. Gamble commented on the recent MSDC Executive Committee Planning Seminar at which he and Mr. Harrison were invited guests. He added that this was reflective of the close working relationship between the staffs of

the two organizations. Dr. Kleh then commented on the MSDC Executive Committee's recent expression of support for the consolidation of the two organizations.

A lengthly discussion then followed regarding the extent of physician awareness of the merger discussions between the two organizations. Issues raised involved the need for the participating physicians to be informed of the issues involving merger and the need for the leadership of the area medical societies to understand the reasons for merger. The opinion was expressed that physicians in the area should be provided with an opportunity to have input into the process before final action is taken. Dr. Kleh stated that he fully agreed with the need for appropriate communication to the physician community and commented that he intended that meetings would be held with the leadership of the several medical societies in the area.

ADJOURNMENT

The meeting was adjourned at 1:20 p.m.

B W Newsome
Secretary

BLUE CROSS AND BLUE SHIELD OF THE NATIONAL CAPITAL AREA

Minutes of the
Meeting of the Board of Trustees
Held in the Offices of BCBSNCA
Washington, D. C.
July 14, 1987

PRESENT

Trustees:	Mary Lou Barker, M.D.	Anna B. J. Marsh
	Charlotte G. Chapman	Robert C. Mayer
	Charles P. Duvall, M.D.	Matthew F. McNulty, Jr., Sc.D.
	William H. Ferguson, M.D.	Peter F. O'Malley
	Ralph W. Frey	Lutrelle F. Parker
	Joseph P. Gamble	Benjamin S. Pecson, M.D.
	Ernest E. Harmon, M.D.	Robert E. Petersen
	Thomas R. Harrison	Edward A. Rankin, M.D.
	Robert W. Langevin, M.D.	George Speck, M.D.
	Ira Laster, Jr., Ph.D.	John E. Sumter, Jr.
	LaSalle D. Leffall, Jr., M.D.	David S. Wiggin
	Peter D. LeNard, M.D.	Leo W. Zajac
Staff:	V. M. Brian	
	B. W. Giuliani	
Counsel:	Jacqueline M. Saue	

ABSENT

Trustees: Donald A. O'Kieffe, M.D.
Charles L. Rickerich, M.D.

Dr. Duvall, chairman, called the meeting to order at 7:00 p.m.

Mr. Giuliani, secretary, stated that the meeting had been duly called and that a quorum was present, whereupon the Chairman stated that it was in order to proceed with the business of the meeting.

MINUTES OF THE MEETING OF THE BOARD OF TRUSTEES - MAY 3, 1987

The Chairman stated that copies of the minutes of the meeting of the board of trustees of May 3, 1987 had been mailed to and noted by the trustees. He then advised the board of one proposed change to the minutes which had been suggested by counsel, Ms. Jacqueline Saue. He stated that the change was on page 21, in the last sentence under the heading "Hare v. GHMSI", where counsel had suggested adding the word "had" following the word "counsel", and adding a new sentence following the word "complaint", so that the last two sentences of that paragraph would now read "...She said counsel had anticipated moving for summary judgment with respect to the bad faith claims count in the complaint. However, as reported earlier, the case settled for $30,016.03."

The Chairman noted that the minutes contained in the trustees' board books reflected these changes, with the respective changes underscored.

There being no additional corrections, it was

VOTED: To approve the minutes of the May 3, 1987 meeting of the board of trustees as circulated and corrected.

MINUTES OF THE MEETING OF THE PROCEDURES REVIEW COMMITTEE - MAY 26, 1987

The Chairman stated that copies of the minutes of the meeting of the Procedures Review Committee of May 26, 1987 had been mailed to and noted by the Committee members. He said the minutes were included in the tentative agenda material for the remaining trustees.

Dr. Langevin, chairman of the Procedures Review Committee, reviewed the first issue discussed by the Committee which pertained to a new generation of lithotriptors, called Exploitation Developpement de l'Applications de la Physique (EDAP), which had been installed at the Fairfax Hospital, and which contained new features which were highly desirable and which might ultimately replace the first generation of lithotriptors. However, he noted that the EDAP lithotriptor had not yet received Food and Drug Administration (FDA) approval, and, therefore, the Committee had concluded that benefits be denied, since, lacking FDA approval, the new procedure should be considered investigative. Mr. Zajac asked about the cost implications of this new equipment, and Dr. Langevin indicated that this equipment was well-recognized in Europe and has achieved superior results, and that the FDA was expected to approve this equipment after an adequate number of cases had been tested in the United States. Dr. Laster expressed concern over the fact that all three proposals considered by the Committee were denied because none of the procedures had been approved by the FDA. He said, therefore, if BCBSNCA's policy is based on FDA approval, he is concerned about wasting the time of the Committee and the applicants that come before the Committee to discuss items not approved by the FDA. Mr. Brian noted that, as a matter of courtesy, such proposals are considered by the Committee, and it was possible that some of the presentations could result in a pilot program even if the procedure(s) had not yet received FDA approval.

Mr. Wiggin said that the FDA did approve the EDAP lithotriptor at Fairfax Hospital for investigative use, and that approval enabled the hospital to recover their cost from other sources. He noted that Fairfax Hospital received a certificate of need from the Commonwealth, and that relative to costs, the older lithotriptors require an inpatient stay and cost $5,000-$7,000 per procedure, whereas the procedure involving the EDAP lithotriptor can be done on an outpatient basis, with a cost of between $3,500-$4,000 per procedure. Mr. Wiggin stated that, therefore, it seemed

appropriate to study the issue while paying for services on both devices, and he raised an issue about the use of FDA approval being short-sighted.

Dr. Langevin stated that the pilot study authorized by the Committee when benefits were approved for the first lithotriptor was close to completion, and the Committee had agreed to let that study come to an appropriate conclusion before entering into another pilot program. Dr. Harmon expressed concern about the time it may take to complete the study of the first lithotriptor. Dr. LeNard stated that the new lithotriptor at Fairfax Hospital was now functioning as an investigational unit, and he noted that it would be a major change to now begin to cover that procedure while it was deemed to be investigational. He stated that when it was no longer considered investigational, a pilot program would come into play. In the meantime, he added that he would find it difficult to consider covering such procedures.

Dr. Laster asked whether or not the Committee discussions included input as to the positions adopted by other Plans, and Dr. Langevin stated that staff does provide that input based upon queries to nearby Plans. Dr. Langevin then reviewed the other two matters considered by the Committee.

Following additional discussion, it was then

VOTED: To accept the minutes of the May 26, 1987 meeting of the Procedures Review Committee as circulated and presented.

MINUTES OF THE MEETING OF THE COMMITTEE ON FINANCE AND INVESTMENT - MAY 26, 1987

The Chairman stated that copies of the minutes of the meeting of the Committee on Finance and Investment of May 26, 1987 had been mailed to and noted by the Committee members. He said the minutes were included in the tentative agenda material for the remaining trustees.

Mr. Harrison commented briefly on the discussions held with the two investment counselors, on the reports presented by Mr. Poffenberger regarding the status of the lines of credit provided subsidiaries, and on the recent developments regarding the Sullivan principles that pertained to companies doing business in South Africa. He also stated that the Committee had authorized staff to liquidate $15 million from the long-term portfolio during the third quarter of 1987 in order to meet the cash needs of the organization.

Following a brief discussion, it was

VOTED: To accept the minutes of the May 26, 1987 meeting of the Committee on Finance and Investment as circulated and presented.

MINUTES OF THE MEETING OF THE ADVERTISING COMMITTEE - JULY 1, 1987

The Chairman stated that draft copies of the minutes of the meeting of the Advertising Committee of July 1, 1987 had been mailed to the Committee members. He said that draft copies of the minutes were also included in the tentative agenda material for the remaining trustees.

Mr. Parker, chairman of the Advertising Committee, noted that the purpose of the meeting was to brief the Committee on the immediate plans and spending to date for the 1987 advertising budget of approximately $1.8 million. He noted that the Committee was pleased with the results of the advertising program and how the money was being spent. He also commented on the "Beautiful Babies" Program, and briefly described that program in which the corporation had become involved in order to enhance our corporate image. He also noted advertising research efforts, and commented on the 1988 Winter Olympics advertising program of the National Association and how BCBSNCA plans to supplement that advertising with local advertising during the 1988 Summer Olympics. Mr. Parker outlined the Committee's discussion of a program called the "Presidential Classroom for Young Americans", which enables high school and college students to attend a week-long conference in Washington, D. C. on national civic affairs issues. He suggested that involvement in such a program would enable BCBSNCA to approach the next generation of potential enrollees, which involve 3,500 students who are brought here each year, only five of whom from the District of Columbia are able to participate in such a program. He stated that staff was going to investigate the program to see whether funds should be contributed to support such a program.

Following a brief discussion, it was then

VOTED: To accept the minutes of the July 1, 1987 meeting of the Advertising Committee as circulated and presented.

MINUTES OF THE MEETING OF THE EXECUTIVE COMMITTEE - JULY 6, 1987

The Chairman stated that draft copies of the minutes of the meeting of the Executive Committee held by telephone on July 6, 1987, had been mailed to the Committee members. He said that draft copies of the minutes were also included in the tentative agenda material for the remaining trustees.

The Chairman stated that the minutes of the Executive Committee meeting had been circulated to the members of the Executive Committee, and, as a result, some suggested changes were made to the minutes and the corrected version of the minutes was included in each trustee's board material. He then called upon Mr. Gamble to explain the situation involving Blue Cross of Jamaica (BCJ).

Mr. Gamble stated that the situation was described in the Executive Committee minutes that were distributed with the tentative agenda, but that he would review the matter in detail. He explained that the Blue Cross Plan in Jamaica had, by necessity of a zoning requirement, entered into a venture to build condominiums, and, as a result, the Plan had developed severe cash flow problems. He said that he had met with Mr. Hylton McIntosh, Executive Director of Blue Cross of Jamaica, to discuss the situation at length. He stated that the strategic importance of our Plan becoming involved with BCJ was that it would enhance BCBSNCA's position in the Caribbean. He commented on the Virgin Islands operation, which was administering the health benefits program for the Government of the Virgin Islands, and noted that BCBSNCA now offers programs to the private sector in the Virgin Islands, and that the present annualized revenue in the private sector was nearly $3.5 million. He said that in the event the Government of the Virgin Islands were to cancel the program in the Virgin Islands, BCBSNCA would still have a need to provide service to the private sector in that part of the world. By being in Jamaica, BCBSNCA would have some options available to it in being able to continue to service these accounts.

Mr. Gamble explained that he envisioned an arrangement whereby Group Hospitalization and Medical Services, Inc. (GHMSI) would take over BCJ, whereupon GHMSI would infuse US$5 million into BCJ to liquidate their real estate debt, as well as to provide them some operating funds. He stated that the US$5 million was equivalent to approximately J$27 million, and with that infused cash, the J$22 million debt could be liquidated, and in return, BCJ would be merged into GHMSI. Mr. Gamble stated that the balance sheet of GHMSI would not change, and the operation in Jamaica would enhance our operation, as it has annual revenues of nearly US$8 million.

Mr. Gamble explained that he had had extended negotiations with Mr. McIntosh and that a draft agreement had been sent to him on Wednesday, July 8, 1987, and that meetings had taken place continuously ever since. He stated that he was originally scheduled to go to Jamaica on Wednesday, July 15, to sign the final contract, but that meeting had now been rescheduled. He stated that a new issue had arisen regarding a law in Jamaica that requires payments to employees in the event that a company is taken over by another organization. He said that the objective was to give BCJ US$5 million, and that BCJ would be merged into GHMSI. GHMSI would then take over BCJ's operation, which would enhance our Caribbean operation.

The Chairman stated that the Executive Committee had given staff the authority to take four actions in connection with Jamaica, but that the board should understand that it was free to either approve these actions, or to modify them, or the entire effort with BCJ could be dissolved. Dr. Harmon noted that the entire discussion with the Executive Committee was done by phone in 35 minutes, which may not have provided the members of the Executive Committee with sufficient time to consider the matter. He then asked for clarification of several matters. One was which position on

the GHMSI board would the person from Jamaica fill. Mr. Gamble stated that no existing board seat would be filled, but that the GHMSI bylaws would have to be amended to take care of that matter. Mr. Gamble also noted that based upon his negotiations, BCBSNCA would have three members on the board of BCJ. Dr. Harmon then asked about concerns that Jamaica would nationalize medical care. Mr. Gamble responded that to BCBSNCA's knowledge, there was no such plan to do so, as BCJ has nearly 53% of the market potential enrolled. Dr. Harmon then asked about the economy in Jamaica, noting that it has been rather poor in the past, and he specifically asked about the BCJ operations. Mr. Gamble noted that last year, BCJ lost approximately J$2.9 million, which was equal to about a half-million dollars in the United States, which would not be much of a burden to sustain under our operations. Dr. Speck expressed concern over the stability of the Jamaican government, as he also noted some difficulties there in the past. Mr. Gamble responded that this should not be a problem based upon the Plan's sources of information. He noted that Price Waterhouse had prepared a report reflecting that a favorable climate exists for foreign investments in Jamaica, and that BCBSNCA staff had made arrangements for Price Waterhouse in Jamaica to review the Plan's operations. Dr. Speck asked what would happen if the government of Jamaica took over the Plan? Mr. Gamble responded that this was not likely to happen, but if it did, he was not sure what our recourse would be.

Mr. Gamble noted that when the condominiums were sold, that would serve as a source of regenerating our US$5 million investment. He also noted that while the December 31, 1986 Jamaica Plan's financial statements reflected J$10 million in reserves, he feels these figures were quite "soft", and that he had discounted their reserves to the point of assuming they were, in essence, zero. Dr. Speck asked whether or not BCBSNCA would be able to get the cash back out of Jamaica, and Mr. Gamble stated that point had already been explored, and that the cash can be repatriated as long as it goes through the Bank of Jamaica. Mr. Sumter stated that he would like to understand more about the real estate that is being sold by the Plan. Mr. Gamble explained that they were semi-luxury, two- and three-bedroom condominiums selling for between J$250,000 and J$300,000. Mr. Gamble explained that the business office of the Jamaica Plan had needed substantial remodeling, and in order to obtain zoning approval to remodel their offices, they also were required to add residential facilities to their property. Mr. Sumter noted that it seemed that the Jamaican Government would be very difficult to work with. He asked how many of the 44 units had been sold, and Mr. Gamble responded that 14-16 units had been sold to date. Mr. Gamble noted that the problem for BCJ was in obtaining financing, and stated that they have loans of nearly J$22 million, on which they are paying interest at 24% per annum, with the value of their real estate being approximately J$31 million on the books of the Plan, but he said he felt that the true value of their real estate holdings was probably J$25 million. Mr. Gamble noted that a US$5 million investment by our Plan would go into the reserves of the Jamaican Plan, and when they subsequently merged into GHMSI, that reserve amount would continue to be reflected in our reserves.

Mr. Gamble noted that the board should understand that BCBSNCA does have a risk in making this investment. Mr. Mayer asked whether or not BCBSNCA had looked into obtaining a government guarantee through the Inter-American Development Bank, and inquired as to whether the program would be available to GHMSI. Mr. Gamble responded that he could not answer the question, but that he had already planned to discuss the matter with the cultural attache', Mr. John Stevens, from the U. S. Embassy in Jamaica. Mr. Mayer suggested that if, during the next election, the Jamaican Government changes and Mr. Manley returns to office, we would have some problems. Mr. Gamble noted that the Jamaican Plan has been in operation for 20-30 years, during which time many different governments have been in power in Jamaica, including that of Mr. Manley.

Mr. O'Malley stated that his questions didn't relate to the stability of the government in Jamaica, or the other matters which have been discussed. He stated that his question pertained to what he believed to be a more basic issue as to what policy of BCBSNCA was being served by virtue of establishing itself in the Jamaican area of the Caribbean. Mr. Gamble responded that the business plan pertaining to the Caribbean had divided that area into seven segments, and he briefly commented on several of those segments, including arrangements with Life of Barbados that involve an offering of health and life insurance to accounts in certain areas of the Caribbean. He stated that similar objectives existed in other parts of the Caribbean. He noted that the President of Life of Barbados had recently contacted him, expressing an interest in extending our current arrangement in Barbados to the Jamaican market if GHMSI's acquisition of BCJ proved to be successful. In response to another question from Mr. O'Malley as to why BCBSNCA was operating in the Caribbean, Mr. Gamble explained that the purpose of operating in the Caribbean, as well as in any other international area, was to broaden the Plan's revenue base, as well as its administrative expense base over which costs may be spread, in order to make BCBSNCA more competitive locally. He stated that a larger revenue base would result in larger reserves being held by the organization, as it was the policy of this board that BCBSNCA maintain in its reserves 25% of its annual earned subscription income. Mr. Gamble also noted that the Federal Employee Program, which makes up 40% of BCBSNCA's present earned subscription income, makes a very low contribution to reserves, and that during BCBSNCA's current three-year cycle of losing money, the Plan's reserves will decrease from $180 million to nearly $100 million, and in order to rebuild those reserves, BCBSNCA must look elsewhere for increases in reserves. He said that international activities enable BCBSNCA to spread its risk over a broader base, become more competitive, and have a smaller portion of our total revenue from one source. He stated that BCBSNCA's strategic long-range goal was to increase revenue from last year's $900 million to nearly $2 billion by 1990.

Mr. O'Malley noted then that this entire effort on the Caribbean was economically driven, and he asked whether or not there was sufficient time to analyze the proposal. Mr. Gamble stated that after the Executive Committee met, Price Waterhouse was retained to obtain some assurances

regarding the financial condition of the Plan. He said that counsel in Jamaica, who is very knowledgeable of the Jamaican environment, was also retained, and has given BCBSNCA constant advice. He stated that the decision to cancel the meeting scheduled for July 15 in Jamaica was made in order to give BCBSNCA more time to make sure all the aspects of this transaction were understood. Mr. Gamble noted that he had assured the Executive Committee that the transaction would be a proper transaction, and if not, he would not follow through with it. Mr. O'Malley asked if the Jamaican transaction was consistent with BCBSNCA's economic plan. Mr. Gamble responded that he believed that it was. He also noted that there were risks, but that they were minimal, in his judgment. He noted that BCJ could be nationalized, or GHMSI could own US$5 million of real estate that could not be sold, but he explained that an opportunity did exist to establish a firm foothold in that part of the world, and that BCBSNCA wants to be a strong player in the Latin and South American communities.

Mr. Frey inquired as to BCJ's operating losses in 1987 as a result of paying 24% interest. Mr. Gamble stated that while BCJ's statements had not been audited, he did believe the numbers to be fairly soft, and that to date, the Plan may have lost J$3 million. He noted that the losses were primarily driven by virtue of paying J$450,000 per month in interest, but that once the loans were paid off by virtue of BCBSNCA infused cash, the losses would disappear.

Mr. Frey asked about the income tax rate in Jamaica, and Mr. Gamble explained that the corporate rate was 33%, but that an issue exists as to whether or not the Jamaican Plan is subject to Jamaican income tax. Mr. Frey also asked whether or not the executive director has a contract to provide him with certain guarantees with regard to employment and/or compensation in the event of takeover by another organization. Mr. Gamble stated that as part of the arrangement, all contracts would have to be disclosed before the transaction was completed. Ms. Saue noted that the contract, as prepared, gives BCBSNCA the opportunity to back-out of the arrangement if BCBSNCA is not satisfied.

Mr. Frey then asked why the approach was to merge the Jamaican Plan into GHMSI, as opposed to incorporating them as a subsidiary. Mr. Gamble stated that this has been an issue which has been discussed at length, and it has been determined that a merger would enable GHMSI to take control of the present operation, whereas a subsidiary would have to apply for a license to be a non-profit organization. He stated there was also the issue of an act in Jamaica called the Job Redundancy Act, which, as noted earlier, provides that employees of an organization must be paid a redundancy payment in the event that the company is taken over by another organization. He stated that BCJ is not a stock corporation but that one could be created and then BCJ transferred into it, but that would not necessarily solve the Redundancy Act problem. He noted that a third alternative, involving GHMSI having control of the appointment of a majority of the BCJ board, was also being considered, but that the members

of the Jamaican Plan would have to approve a change in the makeup of the board to give GHMSI majority control. Mr. Frey noted that in his view, merger appeared to offer the best protection of the corpus.

The Chairman asked counsel if she wished to express any comments, whereupon Ms. Saue noted that the statutes in Jamaica were similar to those in the United States, but they do have some exceptions and those were the ones creating the current issues. She stated that the alternatives presented by Mr. Gamble were being reviewed, and it was hoped to have the issues resolved by Friday, July 17. She explained that an insurance company, named Life of Jamaica, had made an offer to take over BCJ, and that Mr. McIntosh was concerned that the Superintendent of Insurance in Jamaica would turn the Plan over to them, and that issue has caused a great deal of urgency in attempting to resolve this matter. Dr. McNulty asked Ms. Saue to explore the role of the Superintendent of Insurance in Jamaica. Ms. Saue stated that the Superintendent of Insurance wanted someone to take over the Plan in Jamaica, and according to BCJ's counsel, the Superintendent has tentatively okayed the GHMSI takeover. Mr. Gamble stated that it was his understanding that Life of Jamaica was not overly interested in taking over the Plan, as they had no great interest in getting involved with health insurance. Ms. Saue noted that the attorneys for Life of Jamaica had stated that they would put their proposal on hold until BCBSNCA's issue was resolved. Mr. Frey commented that the Long-Range Planning Committee had earlier this year discussed at length what was the business of the organization, and that the conclusion was that BCBSNCA should be in health-related business, as well as life insurance, but should not be involved in casualty insurance. He stated that the proposal to acquire the Plan in Jamaica falls within those specifications, except for the component dealing with real estate. Mr. Frey reminded the board members that he and his Committee would encourage any member of the board to provide input to his Committee if they desire. Mr. O'Malley then noted that this proposal appears to be consistent with both the policies and business plan of the organization. Mr. O'Malley then moved, and it was seconded, that the board amend the actions taken by the Executive Committee, and to further authorize the Executive Committee to take any further action that may be required in this matter which is consistent with the policies of the organization.

After a brief discussion, during which Mr. O'Malley stated that this amendment not only serves to support the actions of the Executive Committee, but also endorses their continued involvement in the matter on behalf of the board, it was then

VOTED: To amend the four actions taken by the Executive Committee to further authorize the Executive Committee to take any additional action that may be required in this matter which is consistent with the policies of the organization.

Mr. Zajac then moved, and it was seconded, to amend the second action of the Executive Committee which reads "...the agreement of BCJ to merge into GHMSI;..." in order to change the word "merge" to the word "affiliate". Following a brief additional discussion, it was then,

VOTED: To amend the second action of the Executive Committee by deleting the word "merge" and replacing it with the word "affiliate".

It was then

VOTED: To approve the minutes of the July 6, 1987 meeting of the Executive Committee as amended by the board actions reflected above.

FINANCIAL STATEMENTS - MAY 31, 1987

Mr. Giuliani presented the financial statements as of May 31, 1987, copies of which had been mailed to the trustees.

Mr. Giuliani reviewed the Comparative Balance Sheet as of May 31, 1987, compared to that same period in 1986. During the 12-month period, he said total assets had increased by $42,453,391.00, and he identified the major items contributing to those increases. During the same 12-month period, he said liabilities had increased by $86,056,661.73, and he identified the significant items contributing to those increases. Mr. Giuliani said that as a result, unallocated reserves had declined $43,603,270.73 over the last 12 months.

Mr. Giuliani then reviewed the Comparative Statement of Earned Income and Incurred Expense as of May 31, 1987. He stated that the total incurred expense for year to date 1987 reflected that for every dollar of subscription income earned, the total incurred expense was in excess of $1.06. He said that this results in the net income from underwriting reflecting a loss during the first five months of this year for non-FEP subscribers of $25,674,549.09.

In response to a question from Mr. Wiggin, Mr. Giuliani explained the substantial underwriting loss for the month of May 1987 as being unusually high due to seasonal variations, noting that certain months, such as January, March, May, July and October, were historically months which reflected very high medical care usage and, therefore, also reflect higher than usual claims expense, which contributes to the higher than usual loss for the month of May 1987. Following another question from Mr. Wiggin, Mr. Giuliani explained that the projection for 1987 was that, from underwriting, BCBSNCA would lose approximately $55 million, and for 1988, BCBSNCA would lose another $15 million from underwriting, which would cause the Plan's reserves to drop to approximately $80-85 million during 1987,

and that in 1989, BCBSNCA would expect to begin to add to reserves again, to the extent of about $15 million in that year. He noted that all projections exclude other income and expenses.

Mr. Wiggin noted that this represented a substantial decline in the Plan's reserves of nearly 50% from the end of 1986, and such a decline should not be looked at lightly. Mr. Gamble noted that medical care trend factors used in rates were a critical element relative to determining underwriting gains and losses. When a trend factor is established, it takes one year to recognize that it may be in error, and once recognized, it takes four to six months before new rates begin to reflect the revised trend factors, and then in total, a year before the new rates are in place for all accounts. Mr. Giuliani also noted that besides being impacted by inadequate trend factors, the underwriting losses being sustained in this particular cycle were also being impacted by administrative expenses being greater than the administrative expense factor included in rates, due to the many changes being made in the organization. He noted that actions had already been taken to address this matter, as the corporate budget has increased less than 2% from 1986 to 1987, and that the total number of employees from a year ago had declined by 200 positions. He noted that this matter was being looked at very seriously by staff, and that corrective actions were being taken by controlling BCBSNCA's costs and substantially increasing rates.

Dr. McNulty requested both information and forecast assessment regarding the increase in claims liability as reflected on the balance sheet. Mr. Giuliani stated that the 1986 liability estimates were understated, and as he had reported to the board in the latter part of last year, it was necessary to further increase the liability, and, therefore, the increases may not be as drastic as indicated. Dr. McNulty then asked if the liabilities were in accordance with the business plan and Mr. Giuliani indicated that they were.

Following a brief additional discussion, it was then

VOTED: To accept the financial statements dated May 31, 1987.

REPORT OF THE CHIEF EXECUTIVE OFFICER

Mr. Gamble reviewed his report, copies of which had been mailed to the trustees.

Utah Proposal

Mr. Gamble stated that recent discussions he had had with Dr. Ralph Macfarlane had indicated that the Utah Plan was moving toward a decision regarding the proposed consolidation with BCBSNCA, although somewhat slower than anticipated. He said that the slowing of the process had occurred because the Utah Plan had eleven proposals before it. He

stated that BCBSNCA staff understood that the selection had been narrowed to two proposals, one of which was the consolidation with BCBSNCA. He reported that BCBSNCA had been informed that a decision would be reached within the next several weeks.

Montgomery County Government's Request for Proposal

Mr. Gamble explained that the Montgomery County Government had enacted legislation in June 1986, calling for the County to contract with an insurer to provide citizens of the County or employees of a County employer with the opportunity to purchase catastrophic health insurance. He stated that the legislation mandated a catastrophic benefit with no greater than a $50,000 deductible, and a provision so that at no time was the County to be held liable for the catastrophic program. Mr. Gamble stated that BCBSNCA had worked closely with Mercer-Meidinger-Hanson, Incorporated, in developing some of the benefit specifications which had been included in the County's Request for Proposal (RFP). He said that after the RFP was issued on April 6, 1987, the Market Research and Product Development Department began designing BCBSNCA's catastrophic benefit in accordance with all the bid specifications. However, he said that Blue Cross and Blue Shield of Maryland (BCBSMD) was awarded the contract on June 15, 1987, since their rates and benefits were almost identical to BCBSNCA's and they were already successfully marketing a catastrophic benefit. Mr. Gamble stated that although BCBSNCA did not receive the County's bid, BCBSNCA would still plan to sell the catastrophic product, through BCBSNCA's Consumer Accounts Strategic Business Unit in BCBSNCA's service area, in the very near future.

Establishment of Joint Venture with Fairfax Hospital Association

Mr. Gamble stated that at the board meeting of July 8, 1986, staff had been authorized to enter into a joint venture with the Fairfax Hospital Association (FHA) to establish a marketing subsidiary to sell health care benefit programs that would be administered by BCBSNCA's subsidiary, National Capital Administrative Services, Inc. He stated that, at that meeting, staff was also authorized to capitalize the joint venture at $200,000 each from BCBSNCA and FHA, and it was agreed that a line of credit of up to $1 million from each party would be provided the joint venture.

Mr. Gamble reported that the corporate name of this joint venture was Emtrust, Inc., and the organizational meeting of the board of directors of Emtrust was held on May 8, 1987. He said that based upon action taken during that meeting, BCBSNCA had subscribed to $200,000 of Class A common stock in Emtrust.

Heart Transplant Consortium

Mr. Gamble reported that in August 1986, BCBSNCA had convened hospitals interested in providing heart transplantation services in the Washington, D. C. metropolitan area, to encourage them to form a regional consortium

for that purpose. He noted that subsequently, BCBSNCA had adopted the position that the Plan would cover heart transplants only when provided under a single regional program which had received a certificate of need, and which had agreed to participate in a 30-36 month BCBSNCA pilot program which would monitor and evaluate program progress and performance.

Mr. Gamble stated that the Washington Regional Heart Transplant Consortium, comprised of the Washington Hospital Center, Georgetown University Hospital, The George Washington University Hospital, Howard University Hospital, Children's Hospital National Medical Center and Fairfax Hospital, had received a certificate of need in the District of Columbia in February 1987. He said that in April 1987, the Consortium had applied to BCBSNCA for participation in BCBSNCA's pilot program, and in mid-May, the Consortium had appointed a manager to administer its activities. He stated that the Consortium had now documented its operations to BCBSNCA, and a pilot program agreement had been drafted for review by the Consortium.

Mr. Gamble stated that in the meantime, Fairfax Hospital, which had received a Virginia certificate of need to perform heart transplants prior to formation of the regional consortium, had now done four transplants, none of them involving BCBSNCA subscribers. He said the Consortium had performed two, both at the Washington Hospital Center. He reported that one of these was a BCBSNCA subscriber, for whom coverage was pre-authorized based upon the Consortium's compliance with the provisions of the pending pilot program agreement. He said benefits for a second BCBSNCA subscriber had also been pre-authorized on the same basis, and the transplant would be performed when a donor heart was secured under the Consortium's organ acquisition program.

Inter-Plan Operational Capability

Mr. Gamble stated that during the March 10, 1987 board meeting, the board had adopted a recommendation of the Committee on Long-Range Planning, and had authorized staff to invest in the development of the Inter-Plan Operational Capability (IPOC) concept, in an amount of up to $2.5 million over a three-year period. Mr. Gamble stated that the purpose of the IPOC activity was to provide the Blue Cross and Blue Shield system of Plans with a national account delivery capability to enable the Plans to be more competitive in the national account marketplace. He said that as he had reported to the board during the March discussions of this matter, four Plans had been involved in developing this new national account delivery capability. He said these Plans were Illinois Blue Cross and Blue Shield, St. Louis, Missouri Blue Cross and Blue Shield, Cincinnati, Ohio Blue Cross and Blue Shield and BCBSNCA. He explained that the delivery capability to be used by this consortium of four Plans had been developed from the system developed by the St. Louis, Missouri Blue Cross and Blue Shield Plan. He said as was also reported during the March meeting, the National Association, through the activities of G. William Miller & Co., Inc., was interested in making an offering to all Plans to invest in BCBSNCA's IPOC organization. He said that should a sufficient number of other Plans agree

to participate, the activities of the four-Plan consortium would be combined with the activities of the other Plans so that only one capability would be developed.

Mr. Gamble said that in order to send a prospectus to the other Plans to learn whether or not they were interested in investing in the development of this capability, it was necessary to finalize the arrangement that the four-Plan consortium would have with the St. Louis, Missouri Plan to develop and operate this national account delivery system. He said such contracts would be included in the prospectus so that the potential investors would fully understand what the arrangements would be before deciding whether or not to become investors. He then stated that negotiations with the Missouri Plan had taken place within the last several months, and based upon a telephone conference call held on July 1, 1987, agreement had finally been reached, and it was expected that the contracts would be signed by the middle of July so that the prospectus could subsequently be issued to Plans. He said Plans would have 90 days in which to decide whether or not to join in this effort. As was also discussed during the March 10, 1987 board meeting, he said that at the end of the 90-day period, the four-Plan consortium would then have the opportunity to decide what it wished to do. He said that it was expected that the decision would most likely be made during November 1987. In the meantime, however, he said development activities had been undertaken by the St. Louis, Missouri Plan to begin to develop this capability, so that by the middle of next year, it could begin to be marketed to Plans to better enable them to service their national account business.

West German Delegation

Mr. Gamble stated that as he had reported to the board at its May 3, 1987, meeting, a delegation from West Germany had visited Blue Cross and Blue Shield of the National Capital Area (BCBSNCA) on May 13, 1987. He said at that time, they had expressed great interest in the various programs which had been initiated to contain medical care costs in the United States. He also said that these programs included the alternative delivery systems of health maintenance organizations, preferred provider arrangements and others. Mr. Gamble said the delegation was also quite interested in the efforts of Health Management Strategies International, Inc., which provides second opinion surgery and pre-certification programs.

Mr. Gamble reported that the visitors had stated that nearly 12% of the German gross national product was now dedicated to health care costs. He said these costs were rising, and the West Germans were actively seeking various means to reduce future rises in health care expenditures. He stated that they would be faced with many of the same issues that were present in current U. S. health care costs, i.e., high technology costs, growing elderly population and other related issues.

Mr. Gamble stated that two members of the delegation, Ms. Gertrude Dempwolf of the German Parliament and Dr. Iur Gerd-Steffen Thiele of the Labor Ministry, had been contacted by members of the BCBSNCA staff to pursue discussions regarding the development of a coalition between BCBSNCA and members of the German government and health care community, for the purpose of studying health care costs and various means of containing those costs. He said that it was expected that in the next few weeks, more definitive information regarding the goals, purpose, structure and development of such a coalition would be developed.

He reported that staff believed that there was a benefit to BCBSNCA in getting an insight into health care systems abroad, and also in developing a broad spectrum of contacts that would result from such a coalition.

American Medical Association Meeting -- June 21-25, 1987

Mr. Gamble stated that Mr. Brian and Dr. Kleh had recently attended the annual business meeting of the American Medical Association (AMA) House of Delegates held in Chicago, Illinois. He said that in addition to reports of the officers, board and councils of AMA, there had been over 130 resolutions introduced by the delegates. The report indicated that Jim Sammons, M.D., the Executive Vice President, had addressed the major problems faced by the medical profession today, including diagnostic related groups, mandatory assignments and professional review organizations under Medicare, the Acquired Immune Deficiency Syndrome (AIDS) situation, and other public health concerns.

Mr. Gamble said that the Blue Cross and Blue Shield Association (BCBSA) staff believed that some 38 of the reports and resolutions would be of interest to Plans, and they would be reviewed during a special meeting of Plan representatives.

He said the main thrust and showpiece of the meeting was AIDS and all of its ramifications. He reported that guidelines were recommended for testing, and one term seemed innovative, "routine voluntary", indicating that for defined situations, testing would be done routinely unless the individual specifically refused.

He then stated while none were particularly threatening to the Blue Cross and Blue Shield system, there would be several resolutions of interest.

He reported that in one of the propoaitions, the New York delegation had asked the AMA to assess the BCBSA Diagnostic Testing Guidelines and delay their implementation. He said this had been referred for study.

Mr. Gamble stated that a reception and dinner for the D. C. Medical Society officers, delegates and their wives was sponsored by BCBSNCA, which Dr. and Mrs. Charles P. Duvall also attended. He said Dr. Duvall is a delegate of the American Society of Internal Medicine. He said that this event, while

not only being a most enjoyable evening, continued to be an effective approach to maintaining a good relationship with some of the leaders in the local medical community.

Status of Acquiring a Life Insurance Capability

Mr. Gamble stated that since the approval at the January 13, 1987 board meeting to adopt the strategic policy of acquiring a life insurance capability, staff had been proceeding with the acquisition of American Capital Life Insurance Company (ACLIC). He said the details regarding the company were reviewed with the board at the January 13, 1987 meeting, and since that time BCBSNCA had had an actuarial evaluation completed by Milliman & Robertson, Inc. and a financial evaluation by Price Waterhouse. He said both of these reviews had been positive, and following a meeting with the D. C. Insurance Department, various acquisition forms were completed and filed on June 30, 1987 with the Department. Mr. Gamble stated as a result, GHMSI, through The GHMSI Companies, Inc., its wholly owned holding company, would acquire from North Carolina Mutual Life Insurance Company (NCMLIC), its 304,206 shares of stock of ACLIC (96.9% of shares outstanding) for $1.5 million. He said a letter had been sent to all minority stockholders by NCMLIC informing them of its action, and a packet of information would also be sent to such stockholders by ACLIC soon. He said that it appeared that the D. C. Insurance Department would hold a hearing on the prospective purchase within the next 30 days, and their approval was expected within 30 days of the hearing date.

Status of Acquiring Directors and Officers' Liability Insurance

Mr. Gamble stated that following up on the purchase of directors and officers' liability coverage through Plans' Liability Insurance Company (PLIC), as reported to the board at its May 3, 1987 meeting, outstanding details were expected to be completed soon. He said a binder payment would be made against the $228,000 annual premium for the $5 million coverage of directors and officers' and errors and omissions liability insurance. He also said a representative of PLIC was scheduled to be at GHMSI the week of July 13, 1987 to finalize the coverage so that the policy could be issued. He said staff expected the policy to be issued by the end of July.

Medicare Part A Contract

In response to a question from Dr. Speck, Mr. Gamble reviewed the background information which led up to GHMSI cancelling the Medicare Part A contract effective March 31, 1988.

Mr. Gamble stated that the Health Care Financing Administration (HCFA) decided to reduce the number of intermediaries, and they identified BCBSNCA as being in the lowest 20th percentile of all Medicare intermediaries based upon performance, and further, deemed BCBSNCA to be an easy intermediary to cancel, given our location and the relatively small Medicare operation that

the Plan had. He said that in deciding to cancel BCBSNCA's program based upon performance, HCFA made some serious mistakes, and, as a result, as had been previously reported to the board, BCBSNCA sued the federal government. Shortly thereafter, the attorneys representing the federal government approached BCBSNCA's attorneys regarding a possible settlement.

In reviewing the possibilities, BCBSNCA staff had concluded that it had a very good chance of winning the lawsuit, which would enable BCBSNCA to stay in the Medicare program, but BCBSNCA's attorneys had advised staff that at any time which HCFA desired, they could simply decide not to renew BCBSNCA's contract and not use performance as a basis of such a decision, and BCBSNCA would have little or no grounds to protect itself. He said this would effectively result in HCFA eliminating BCBSNCA as an intermediary.

Accordingly, BCBSNCA decided to terminate its involvement in the program, but to leverage the settlement process to enable BCBSNCA to terminate under the best of terms. Mr. Gamble noted that BCBSNCA had a small Medicare operation. He said as time passes, Medicare is going to require stricter performance levels, and at the same time, cut back on the budget. He said this meant that BCBSNCA would not be getting back its full costs, and as a result, BCBSNCA would be losing money by administering the program for the federal government.

Mr. Gamble said the representatives for the National Association had advised staff that the termination costs associated with any terminated intermediary were becoming more and more restrictive in terms of recovery of such costs. Mr. Gamble stated that accordingly, BCBSNCA has had to develop a strategy which specifically resulted in its recovering its full termination costs, including legal fees, and, therefore, on balance, it was a good settlement for BCBSNCA. Furthermore, BCBSNCA was able to get the Blue Cross and Blue Shield system to retain the business. He said that this was an advantage to the system.

Dr. Speck inquired about the aspect of losing money on the Medicare program. Mr. Gamble responded that if BCBSNCA stayed in the program, it would have lost money because of limitations on expense reimbursements by HCFA. Mr. Gamble also noted that the settlement provisions also reflected BCBSNCA's interest in protecting providers, in that BCBSNCA retained the right to assist providers if they have any difficulties in dealing with either the Virginia or the Maryland Plans relative to the Medicare Part A program.

Mr. Parker asked whether or not, given the history of the arguments over the service area in Northern Virginia, this would not serve to strengthen the Virginia Plan's position. Mr. Gamble stated that staff debated this issue in length and concluded that the Richmond Plan's involvement in Medicare Part A would not enhance their position. Furthermore, he noted

that through the efforts of Mr. Brian and Mr. Giuliani, meetings have been held with representatives of the Virginia Plan to begin to improve relationships with that Plan.

It was then

VOTED: To accept the report of the Chief Executive Officer dated July 14, 1987.

LEGAL COUNSEL'S REPORT

Ms. Saue explained that Mr. Steele was originally scheduled to attend the meeting but that he had been delayed because of a deposition pertaining to the Smith case. Ms. Saue then presented the Legal Counsel's report, copies of which had been mailed to the trustees.

Group Hospitalization and Medical Services, Inc. v. Blue Cross and Blue Shield of Virginia (the Alexandria service area litigation)

Ms. Saue explained that since the last board meeting, the United States Court of Appeals for the Fourth Circuit had affirmed the decision of the United States District Court for the Eastern District of Virginia in all respects. Ms. Saue said that this meant that the line dividing the exclusive service areas between BCBSNCA and the Richmond plan remained Route 123, except that BCBSNCA's service area also included the incorporated city of Fairfax and the incorporated town of Vienna, including portions of both municipalities which extend beyond Route 123. She said counsel continued to believe that this dividing line enlarged the service area of the Richmond Plan at the expense of BCBSNCA. Ms. Saue explained that the Fourth Circuit basically held that the order of the State Corporation Commission granting exclusive service areas to the D. C. and Richmond Plans in 1955 was ambiguous, and that Judge Bryan had not committed plain error in arriving at the dividing line which he had. Ms. Saue said that counsel had petitioned the Court of Appeals for a rehearing en banc. She explained that Courts of Appeal in general, and the Fourth Circuit in particular, rarely grant such petitions, but based on counsel's strong belief that both the trial court and the Court of Appeals were wrong, the petition was filed. She said that as of the date of this report, the Fourth Circuit had not acted on the petition.

Ms. Saue further explained that the ruling dismissing BCBSNCA's counterclaim against the Richmond Plan for allegedly selling to groups inside Route 123 had been upheld. She said that the Fourth Circuit, in a view that was clearly erroneous, held that the decision with respect to where the dividing line was, mooted that issue. She explained that while it did not, it was clear from the decision that the Richmond Plan cannot, from this point on, sell to groups on the Washington, D. C. side of Route 123.

Ms. Saue stated that Judge Bryan's ruling in BCBSNCA's favor denying monetary damages to the Richmond Plan had been upheld.

Smith v. GHMSI

Ms. Saue reported that this case would go to trial on July 20. She said that the trial would be limited to the breach of contract issue, the court having granted BCBSNCA's motion for partial summary judgment, striking the claim for punitive damages. She stated that this was discussed in the April 21, 1987 report to the board of trustees which was presented at the May 3, 1987 board meeting. She said that the amount at issue was approximately $700,000.

Sylvia Anderson v. GHMSI

Ms. Saue explained that on June 12, 1987 the United States Court of Appeals for the District of Columbia Circuit had affirmed a jury verdict in favor of former employee Sylvia Anderson, who had filed a Title VII (race discrimination) action based on her July 1981 resignation from GHI. She said that the case had been tried twice. She stated that the first trial had ended in a hung jury, with four jurors voting for a verdict for defendant GHI and two jurors favoring Ms. Anderson. She said that in the second trial, a jury had awarded Ms. Anderson back pay, $100,000 in damages, and reinstatement. She said that the Court of Appeals, commenting that "a reviewing court is not to substitute its judgment for that of the jury nor weigh the credibility of witnesses", found that Ms. Anderson had presented "sufficient evidence from which the jury could reasonably find for [her]". Ms. Saue said that the Court of Appeals restated the rule that "a motion for [a judgment notwithstanding the verdict] should not be granted unless the evidence, together with all inferences that can reasonably be drawn therefrom is so one-sided that reasonable men could not disagree on the verdict."

Ms. Saue then discussed with the trustees litigation to which BCBSNCA was not a party, but which she thought would be of interest to the trustees.

Pilot Life Insurance Co. v. Dedeaux, 107 S.Ct. 1549 (1987)

Ms. Saue said that in a case of major importance to insurers in general, and health insurers in particular, the Supreme Court, in April, held that ERISA prempts the state tort of bad faith claims denial (and other state laws) when the insurance is obtained as part of an employee benefit plan. She explained that ERISA does not cover all subscribers. She said that for example, it does not cover federal, state and municipal employees, and probably does not cover subscribers whose coverage is through membership in associations rather than through an employer. Ms. Saue explained that with respect to employee benefit plans, however, Dedeaux holds that ERISA provides the sole remedy with respect to claims denials. She said that among other things, this means the plaintiff must bring the suit in federal court or the defendant can remove it to federal court, that the plaintiff

is not entitled to a jury trial, and that the plaintiff is not entitled to punitive damages for bad faith claims denial under the state torts of bad faith claims.

Hayes v. Prudential Insurance Company

Ms. Saue stated that this case was decided by the United States Court of Appeals for the Ninth Circuit on June 15, 1987. She said that in general, it does for federal employees what Dedeaux does for employees in the private sector. Ms. Saue said that Hayes holds that the Federal Employees Health Benefits Act under which health insurance, including Blue Cross and Blue Shield service benefits, preempts state laws which would affect the uniformity of benefits under the Federal Employee Program. She said that at least where the Ninth Circuit holds sway, this means that federal employees were not entitled to punitive damages for alleged bad faith claims denial. She stated that the opinion of the Ninth Circuit is persuasive but not binding in the District of Columbia, Maryland and Virginia.

Reazin v. Blue Cross and Blue Shield of Kansas

Ms. Saue reported that on May 22, 1987, the United States District Court for the District of Kansas denied the motion of Blue Cross and Blue Shield of Kansas for a judgment notwithstanding the verdict or for a new trial, and granted summary judgment against Blue Cross and Blue Shield of Kansas in connection with a counterclaim which it had filed against Hospital Corporation of America and others. She said that the Court's opinion was over 200 pages in length and did not attempt to summarize it. Ms. Saue stated that Counsel has read the opinion carefully several times and would be prepared to discuss it should the board so desire.

Ms. Saue stated that in the opinion, the Court upheld antitrust damages against Blue Cross and Blue Shield of Kansas in the amount of $4,628,940, punitive damages for tortious interference in the contractual relationships between Wesley Hospital and Blue Cross subscribers in the amount of $750,000, nominal damages of $1.00, plaintiff's attorney's fees in the amount of $2,176,983.75, expert witness fees and related items in the amount of $209,767.77, and allowable court costs of $37,077.22.

Pennsylvania Blue Shield and Pennsylvania Blue Cross v. Muir, Acting Insurance Commissioner of Pennsylvania

Ms. Saue reported that in this important decision, the United States Court of Appeals for the Third Circuit has reversed the United States District Court which had held that even though Blue Cross and Blue Shield of Pennsylvania was acting only as a third-party administrator and not as an underwriter, it was engaged in the business of insurance and therefore was subject to Pennsylvania mandated benefit laws. She said that the reversal by the Third Circuit was particularly important because language in the lower court's opinion could be construed to mean that had the employer,

Bethlehem Steel Company, used a commercial carrier rather than Blue Cross and Blue Shield, it might not be bound by Pennsylvania's mandated benefit statutes.

Ms. Saue noted that in this case, Pierson, Ball & Dowd had filed an amicus brief urging reversal on behalf of the Washington Business Group on Health.

It was then

VOTED: To accept the Legal Counsel's Report as presented July 14, 1987.

REPORT ON HEWITT ASSOCIATES' INVESTMENT PERFORMANCE REVIEW

Mr. Giuliani presented a report titled, "Hewitt Associates' Investment Performance Review", dated July 14, 1987, copies of which had been mailed to the trustees.

Mr. Giuliani reported that, in addition to the BCBSNCA corporate investment portfolio, which was under the direction of the Committee on Finance and Investment, BCBSNCA also has two other investment portfolios under its responsibility -- the GHMSI Pension Trust Plan portfolio and the GHMSI Employees' Thrift Plan portfolio. He said that except for the short-term portion of the BCBSNCA corporate portfolio which was managed by staff, all other funds were managed by outside investment organizations. He stated that the BCBSNCA long-term corporate portfolio currently has five investment management firms. He said that Jundt/Capen Associates, Inc., Thompson, Siegel & Walmsley, Inc. and Trust Company of the West manage the equity portion of the portfolio, with market values as of December 31, 1986 of $24.1 million, $33.4 million, and $56.7 million, respectively, while Criterion Investment Management Company and ASB Capital Management, Inc. manage the fixed-income portion of the portfolio, with market values of $16.8 million and $20.6 million, respectively.

Mr. Giuliani said that the GHMSI Pension Trust Plan portfolio, valued at $75.5 million as of December 31, 1986, was managed by ASB Capital Management, Inc., and the $12.7 million Employees' Thrift Plan portfolio was managed by Dreyfus Management, Inc.

He stated that in order to monitor the performance of each of these investment management organizations, BCBSNCA had selected the firm of Hewitt Associates, a national actuarial firm with headquarters in Chicago, Illinois, to provide comparative investment performance data for these portfolios.

Mr. Giuliani said that the portion of the Hewitt Associates' report for the year 1986 relative to the performance of the BCBSNCA corporate portfolio had been reviewed by the BCBSNCA Committee on Finance and Investment; the Pension Trust Plan portion by the GHMSI Pension Trust Plan Trustees; and

the Thrift Plan portion by the GHMSI Thrift Plan Administration Committee. He explained that representatives of the appropriate investment management organizations generally attend each meeting during which the investment performance of the respective portfolios is reviewed.

He said that as a matter of policy, each committee responsible for an investment portfolio reviews the annual performance of the portfolio using the Hewitt Associates' data to determine that the total rate of return on the portfolios under the responsibility of BCBSNCA is reasonable when compared with the performance of other portfolio managers. He explained that to assist in this matter, the Hewitt data reflects the percentile ranking of the investment performance for each portfolio, whereby the best performance of the approximately 300 portfolios reviewed by Hewitt in 1986 would fall in the 99th percentile, and the 50th percentile would reflect that one-half of all other portfolios reviewed had better performance. He said that based upon the 1986 Hewitt report, the comparative portfolio performance for the year 1986 and the cumulative performance for the period indicated were as shown on the table which was attached to the report.

In reviewing the cumulative percentile performance for the various investment managers since they assume responsibility for managing a portion of BCBSNCA's portfolios, Mr. Giuliani noted that, of the seven managers, six managers' cumulative performance exceeded the minimum acceptable performance level of being in the 60th percentile. The seventh manager, Thompson, Siegel & Wamsley, Inc., which is primarily an equity manager, ranked in the 41st percentile so far as equities, and the Committee on Finance and Investment will be closely monitoring their results.

Following a discussion, it was

VOTED: To accept the report titled "Hewitt Associates' Investment Performance Review", dated July 14, 1987.

REPORT OF THE TRUSTEES OF THE GROUP HOSPITALIZATION AND MEDICAL SERVICES, INC. PENSION TRUST PLAN FOR THE PLAN YEAR ENDED DECEMBER 31, 1986

Mr. Brian presented a report titled "Report of the Trustees of the Group Hospitalization and Medical Services, Inc. Pension Trust Plan for the Plan Year Ended December 31, 1986", dated July 14, 1987, copies of which had been mailed to the trustees.

Mr. Brian stated that during the year ended December 31, 1986, 840 employees had joined the Pension Trust Plan, 253 participants had resigned, two participants had died, and four participants had retired. He said that of the participants who had resigned, 19 had been eligible for a deferred retirement benefit at age 62, three had been eligible for a deferred retirement benefit at age 57, and six had been eligible for a lump-sum payment in lieu of a deferred retirement benefit at age 62.

Mr. Brian said that as of December 31, 1986, the Pension Plan had 2,570 active participants (including 82 participants employed by the six subsidiaries that had adopted the Plan), 39 retirees, six spouses of deceased retirees, nine spouses of deceased active employees, two minor children of a deceased active employee, four former employees receiving a deferred retirement benefit, and 157 former employees eligible for future deferred retirement benefits.

Mr. Brian said that the GHMSI Pension Plan Document had been revised January 1, 1985 to provide for a cash-out of vested benefits with a maximum value of $3,500 without the consent of the participant, and vested benefits with a value between $3,501 and $5,000 with the consent of the participant. He explained that these changes were in accordance with the provisions of the Retirement Equity Act. He said that as of June 30, 1986, there were 95 vested participants eligible for a deferred benefit from the Pension Trust Plan valued at $5,000 or less. He explained that BCBSNCA did not have a current address for 25 of these participants, and that no response had been received from an additional 16 participants. He said that lump-sum payments had been made to the remaining 54 vested participants, which had amounted to a total payout of $135,524.63. He explained that two of these former employees had subsequently been rehired, but had elected not to repay the lump-sum payment they had received, and, therefore, had forfeited any prior service credit under the Plan.

Mr. Brian said the market value of the Pension Trust Fund on January 1, 1986 was $62,759,156. He said that during the year ended December 31, 1986, a total of $4,335,067 had been paid into the Fund. Mr. Brian explained that benefits in the amount of $417,508.07 had been paid to 38 retirees (one retiree had deferred payment of his benefits until age 62), $62,148.96 had been paid to six spouses of deceased retirees, $69,111.00 had been paid to nine spouses of deceased employees, $2,548.44 had been paid to two minor dependent children of a deceased employee, and $19,997.88 had been paid to four former employees eligible for a deferred retirement benefit.

Mr. Brian stated that net investment income earned during the year ended December 31, 1986 was $3,676,013. He said that the market value of the Fund was $75,517,536 on December 31, 1986, reflecting an increase in market value of $13,065,921 during the year. Mr. Brian said the total yield was 16.6% for the year.

Mr. Brian reported that the actuarial consulting firm's annual valuation of the Pension Trust Plan had indicated that the annual contribution for the year beginning January 1, 1986 was 6.91% of payroll. He said that BCBSNCA had been advised by the actuarial consulting firm that, based on current IRS minimum funding regulations, the Pension Trust Plan was adequately funded at this time, so it would not be necessary to make a contribution to the Plan for the year beginning January 1, 1987.

Mr. Brian said that the actuarial valuation for the Plan year beginning January 1, 1987 indicated that while the assets of the Plan were $63,324,374 as of January 1, 1987, the value of accrued vested benefits was $28,801,705 as of that date, while the value of all accrued benefits was $25,746,247.

Mr. Brian reported that the Pension Plan Trustees had met with a representative of the Plan's investment counselor twice during the year to review the cash flow and investment results for the Pension Trust Fund. He said that at the April 15, 1986 meeting, the Trustees also met with a representative of Hewitt Associates to review the annual performance evaluation report prepared by Hewitt for the GHMSI Pension Trust Fund.

Mr. Frey asked whether or not the excess funding in the Pension Plan can be used by the Corporation and he was advised that BCBSNCA cannot obtain access to the excess funds in the portfolio, but because there are excess funds in the portfolio, there will be no need to fund the Pension Plan during the years 1987 and 1988, and possibly all or part of 1989.

It was then

VOTED: To accept the report titled "Report of the Trustees of the Group Hospitalization and Medical Services, Inc., Pension Trust Plan for the Plan Year Ended December 31, 1986", dated July 14, 1987.

REPORT ON THE EMPLOYEES' THRIFT PLAN ADMINISTRATION COMMITTEE FOR THE PLAN YEAR ENDED DECEMBER 31, 1986

Mr. Brian presented a report titled "Employees' Thrift Plan Administration Committee for the Plan Year Ended December 31, 1986", dated July 14, 1987, copies of which had been mailed to the trustees.

Mr. Brian said that the Employees' Thrift Plan had completed 17 years of operation on December 31, 1986, with 2,673 active participants, 283 participants in suspension, and five retirees and two spouses of deceased retirees receiving monthly payments from the Plan. Mr. Brian said this represented a total of 2,963 participants. During the year ended December 31, 1986, he said 655 employees had joined the Thrift Plan and 378 participants had terminated employment.

Mr. Brian reported that the market value of Fund A (a balanced fund) on December 31, 1985 was $10,989,170, and the market value of Fund B (a money market fund) was $6,426,895. He said that during the year ended December 31, 1986, the company had contributed $1,945,443 to Fund A and $1,269,961 to Fund B, and employees had contributed $1,418,476 to Fund A and $853,318 to Fund B. He stated that withdrawals during the year had

totaled $3,165,230 from Fund A and $1,869,450 from Fund B. He said inter-fund transfers had totaled $55,553 from Fund A to Fund B, and $557,180 from Fund B to Fund A.

Mr. Brian said that net investment income earned during the year was $1,446,468 for Fund A. He stated that the market value of Fund A on December 31, 1986 was $13,200,073, and that the total yield for Fund A for the year ended December 31, 1986 was 13.11%. Mr. Brian said that the market value of Fund B on December 31, 1986 was $6,705,317, and the total yield for the year was 6.54%. Mr. Brian stated that net investment income earned during 1986 was $415,335 for Fund B. He said that the combined market value of Fund A and Fund B on December 31, 1986 was $19,905,390, reflecting an appreciation of $2,489,325 for the year.

He said that the Thrift Plan Administration Committee had met 13 times during the year. He stated that in addition to regular monthly meetings to review "financial need" withdrawals, the Committee had met in April with representatives of Dreyfus Management, Inc. and Hewitt Associates to review the Funds' performance, and in October with a representative of Pierson, Ball & Dowd to discuss the Tax Reform Act of 1986 and how it affected the Thrift Plan.

It was then

VOTED: To accept the report titled "Report on Employees' Thrift Plan Administration Committee for the Plan Year Ended December 31, 1986", dated July 14, 1987.

PROPOSED REVISION IN THE SALARY ADMINISTRATION PROGRAM

Mr. Brian presented a report titled "Proposed Revision in the Salary Administration Program", dated July 14, 1987, copies of which had been mailed to the trustees.

Mr. Brian reported that since the formal adoption of BCBSNCA's salary administration program in 1956, and adoption of a revised program in 1977, BCBSNCA has strived to maintain internal equity as well as external equity.

He said that in order to maintain these equities, it has been necessary to evaluate the many jobs at BCBSNCA, and establish salary ranges properly related to the complexity of the work. He stated that it also has been necessary for BCBSNCA to periodically compare its salary ranges and job descriptions with the salary ranges of similar job descriptions used by other major employers in this area. He said that the Plan's compensation consultants, Booz, Allen & Hamilton Inc., had recommended that these comparisons be made annually.

Mr. Brian said that a survey of 15 other Blue Cross and Blue Shield Plans had revealed that 14 of those Plans had made salary changes since last year's survey, and the average increase had been 5.3%.

He stated that the Bureau of Labor Statistics recently announced that the average wage of all wage earners and clerical workers in the Washington, D. C. area had risen by 2.9% between March 1986 and March 1987.

He reported that BCBSNCA's annual salary survey had recently been conducted to determine the Plan's relative standing within the marketplace, and to determine what area businesses were planning as 1987-88 compensation goals. He said that fifteen companies had participated in the survey, and 22 positions had been surveyed. He explained that the survey had revealed that ten of the 15 companies had made salary changes since last year's survey, with the average increase being 4.6%. He said that four other companies had indicated they would be making a change between now and August 1987, and six more were planning a change before May 1988. He stated that in all, ten of the 15 companies were planning another range change before next August.

Mr. Brian said that in making the salary survey and using it to compare relative salaries with those of other companies, BCBSNCA had selected key positions within grades 1 through 8, and five exempt positions, to match with similar jobs in other corporations. He said that the key non-exempt positions were typical to most companies, and reflected the actual spread between the bottom and the top of non-exempt salaries in these companies.

Mr. Brian reported that based on the local survey data, the range change data from other Blue Cross and Blue Shield Plans, and other published salary data, staff believed that an adjustment to BCBSNCA's salary ranges was needed to enable the Plan to continue to retain and attract qualified employees in the labor market. He said that accordingly, staff recommended that the minimums and maximums of grades 1 through 18 and grades 41 through 44, which represented all grades other than those assigned to officer positions, be increased 4%, effective with the pay period beginning August 8, 1987. He said that attached to the report were exhibits that reflected a comparison of BCBSNCA's present and proposed salary minimums and maximums, with the averages for the surveyed companies, as well as the ranking of present minimum salary levels among the 15 companies, the Office of Personnel Management (OPM), and BCBSNCA, along with the ranking which would occur if the proposed adjustment was approved. He said that this revision achieved close comparability with the averages of the minimums and maximums of the key positions in the surveyed companies, and should help BCBSNCA remain reasonably competitive at all grade levels.

Mr. Brian said that BCBSNCA's compensation consultants had also recommended that, in order to maintain proper program balance, an adjustment should be made to the merit guideline percentage tables whenever range changes are significantly higher or lower than the 6%-7% level. He stated that since this year's 4% recommendation was significantly lower than that level,

staff had also recommended that effective August 8, 1987, the merit guideline percentages for non-exempt employees be reduced by .5% for employees who were below or at the midpoint and by 1% for employees who were above the midpoint, and that the merit guideline percentages for exempt employees be reduced by 1%.

Mr. Brian explained that no adjustments in the salaries of all existing employees would be made; he said, however, it would be necessary to accelerate merit review schedules for a few employees, particularly those whose existing salaries would be less than the new minimum for the grade.

Dr. Langevin asked about the additional cost of providing a 4% increase in the minimums and maximums. As proposed in the report, Mr. Brian responded that it is approximately $100,000. Mr. Wiggin asked, "What is the overall average increase merit review received by employees under this proposal?", and he was advised that the expected merit review increase range would be in the range of 6-7%.

It was then

VOTED: To accept the report titled "Proposed Revision in the Salary Administration Program", dated July 14, 1986, and to adopt the recommendations of BCBSNCA staff to increase the minimums and maximums of grades 1 through 18 and grades 41 through 44 by 4%, effective with the pay period beginning August 8, 1987, and that also effective on that date, the merit guideline percentages for non-exempt employees be reduced by .5% for employees who are below or at the mid-point, and by 1% for employees who are above the mid-point, and that the merit guideline percentages for exempt employees be reduced by 1%.

REPORT OF THE NOMINATING COMMITTEE

Mr. Zajac presented a report titled "Report of the Nominating Committee", dated July 14, 1987, copies of which had been mailed to the trustees.

Mr. Zajac reported that on April 9, 1987, John T. Hazel, Jr. had resigned as a member of the board of trustees. He said that subsequent to that date, discussions had taken place regarding a person to fill the vacancy created by Mr. Hazel's resignation. He said the Committee had concluded that Mr. Victor E. Millar would be a most desirable candidate for that position.

The report indicated that Mr. Millar had been associated with Arthur Anderson & Co. for about 30 years, most recently being responsible for the worldwide professional practices of the firm. Mr. Zajac said Mr. Millar

had recently been named Chairman and Chief Executive Officer of Saatchi & Saatchi Consulting Ltd., based in Washington, D. C. Further information regarding Mr. Millar was attached to the report.

Mr. Zajac stated that Dr. Duvall and Mr. Gamble had met with Mr. Millar recently to determine whether Mr. Millar would have an interest in serving on BCBSNCA's board, if nominated, and Mr. Millar had indicated that he would. Mr. Zajac said that the Committee, therefore, nominated Victor E. Millar to fill the unexpired term of John T. Hazel, Jr., as a trustee of Blue Cross and Blue Shield of the National Capital Area.

It was then

VOTED: To unanimously elect Victor E. Millar to serve as a trustee of Blue Cross and Blue Shield of the National Capital Area to fill the unexpired term of John T. Hazel, Jr., to be effective at the close of the July 14, 1987 meeting.

OTHER BUSINESS

Hospital-based Physicians Under the Preferred Provider Program

Dr. Barker noted that under the BCBSNCA Preferred Provider Program (PPP) contracts, Sibley Hospital is to require that the departments of Radiology, Pathology, and Anesthesiology have a minimum of 50% of all physicians in each department as Preferred Provider physicians. Dr. Barker stated that only one person in the three departments actually participates in the Preferred Provider Program, and she expressed concern that this does not appear to be an equitable position because there are no requirements for minimum participation among the other physicians practicing at the hospital. Dr. Barker stated that the hospital has put pressure on the physicians in these three departments, and she suggested that this approach taken by BCBSNCA with our Preferred Provider Program be readdressed by the Professional Affairs Committee, and she so moved.

Mr. Gamble explained that the reason for the requirement for a Preferred Provider hospital to have a good number of radiologists, pathologists and anesthesiologists to be Preferred Provider physicians was because when a patient is admitted to a Preferred Provider hospital, there is a definite inference that the physicians who will be assigned to his/her case, whom they have no choice in selecting, will also be Preferred Providers, which would result in no penalties to the patient. When the physician(s) assigned is not a Preferred Provider, the patient, upon discharge, then finds that to be the case and is very unhappy, and a penalty payment is required to be made by the patient.

Mr. Gamble noted that all but Sibley Hospital have obtained 40-60% of such physicians in radiology, pathology and anesthesia as Preferred Provider physicians.

It was agreed that there may be a problem of understanding the issues involved in this matter, and, therefore, it was then

VOTED: To refer this matter to the Professional Provider Relations Committee.

Change in Reimbursement Levels for Opthamologists

Dr. Harmon stated that he had received three letters from opthamologists in Montgomery County, Maryland, the District of Columbia and Northern Virginia, complaining that they received, with little advance notice, notification of the change in the reimbursement level for certain repeated opthamology procedures. Dr. Harmon stated that upon looking into this matter, he found that all physician members of the board had received a copy of these letters and that the individuals who sent the letters would have been better served to send such letters to all board members. He stated that he contacted staff to discuss who made the decision, and who was involved in considering this matter, and he noted that if the physicians on the board are to represent physician interest, then the physicians have a right to know of actions to be taken on this matter. He stated that the matter is now being addressed to Dr. Jack Kleh, Senior Medical Director, and the question is "On what does he make his judgment?". Mr. Gamble observed that as a result of merger, there have been a lot of changes that have taken place, and perhaps at the staff level, something has fallen between the cracks, and as a result, staff would look into this matter. Dr. Speck stated that he also received these letters, and that this matter should be under the purview of his Committee, and that he had discussed this matter with Mr. Grant Turner and he expected to hear from staff within ten days in order to rectify this matter.

It was then agreed that staff would develop a position on this matter, refer the issue to Dr. Speck's Committee, and have the Committee report back to the board on its conclusions.

Fair Lakes

Mr. Gamble reminded the board that BCBSNCA had acquired land in Fairfax County which would enable the Plan to build up to 275,000 square feet of office space above ground. He stated that staff had recently assessed its future needs, and at this time, staff sees no immediate need for the office space to be built in Fairfax County, and he said staff would continue to evaluate this matter.

Board Seminars

Mr. Gamble announced that as a result of the many comments heard at this year's May Board Seminar, it has been decided to hold the Seminar at The Greenbrier every other year, and during the intervening year, it will be held at Williamsburg and The Homestead on a rotating basis. He then stated that the 1988 Board Seminar would be held in Williamsburg, Virginia, May 5-8, 1988, and that the 1989 Board Seminar would be held at The Greenbrier, White Sulphur Springs, West Virginia, May 4-7, 1989.

Non-Smoking Rule for Board Meetings

Dr. Speck stated that recent studies have indicated that passive smoking can impact non-smokers, and since the board meetings only last for a duration of two hours, he suggested that we ask the smoking members of the board to abstain from smoking during board meetings. Mr. Gamble stated he appreciated Dr. Speck's comments, but that he did not feel that smoking should be one of the criteria for serving on the BCBSNCA board or senior management team. He said that when he seeks new board members, he did not feel it prudent to impose a requirement that he find out whether they smoke or not, and suggested that to do so would inhibit the selection process of new board members. Dr. Speck commented to Mr. Gamble that he did not wish smoking to be a measure of one's ability to serve on the board, but that non-smoking be observed during the board meeting. Mr. Parker indicated that he would find it difficult to support the motion. There was then a move to adjourn the meeting.

ADJOURNMENT

The meeting was adjourned at 9:10 p.m.

GROUP HOSPITALIZATION AND MEDICAL SERVICES, INC.

Minutes of the
Meeting of the Board of Trustees
Held in the Offices of GHMSI
Washington, D. C.
July 14, 1992

PRESENT

Trustees:	Charlotte G. Chapman	Victor E. Millar
	Charles P. Duvall, M.D.	Charles T. Nason
	Ralph W. Frey	Lutrelle F. Parker
	Joseph P. Gamble	Benjamin S. Pecson, M.D.
	Thomas R. Harrison	Robert E. Petersen
	Ira Laster, Jr., Ph.D.	Mallory Walker
	Peter D. LeNard, M.D.	David S. Wiggin
	Robert C. Mayer	Leo W. Zajac
Staff:	R. A. Cook	
	B. W. Giuliani	
	D. H. Kestel	
	S. J. Pace	
	W. B. Poffenberger	
Counsel:	Jacqueline M. Saue	
	Charles J. Steele	

Dr. Duvall, chairman, called the meeting to order at 4:09 p.m.

Mr. Cook, secretary, stated that the meeting had been duly called and that a quorum was present, whereupon the Chairman stated that it was in order to proceed with the business of the meeting.

MINUTES OF THE MEETING OF THE LONG-RANGE PLANNING COMMITTEE - MAY 15, 1992

The Chairman noted that the deliberations of the Committee on May 15, 1992 were reported to the GHMSI board of trustees on May 17, and that the minutes had since been distributed to and noted by Committee members. He said the minutes had also been distributed to all trustees with the tentative agenda material and were before the trustees for acceptance.

It was then

VOTED: To accept the minutes of the May 15, 1992 meeting of the Long-Range Planning Committee, and to adopt the recommendations contained therein.

MINUTES OF THE MEETING OF THE BOARD OF TRUSTEES - MAY 17, 1992

The Chairman stated that copies of the minutes of the meeting of the board of trustees of May 17, 1992 had been n iled to and noted by the trustees.

There being no corrections, it was

VOTED: To approve the minutes of the May 17, 1992 meeting of the board of trustees as circulated and presented.

MINUTES OF THE MEETING OF THE EXECUTIVE COMMITTEE - JUNE 9, 1992

Dr. Duvall, chairman of the Executive Committee, presented the minutes of the June 9, 1992 meeting of the Committee. He stated that the minutes had been mailed to and noted by the Committee members. He said the minutes were included in the tentative agenda material for the remaining trustees.

Following a discussion, it was

VOTED: To approve the minutes of the June 9, 1992 meeting of the Executive Committee as circulated and presented.

MINUTES OF THE MEETING OF THE EXECUTIVE COMMITTEE - JULY 6, 1992

Dr. Duvall, chairman of the Executive Committee, presented the minutes of the July 6, 1992 meeting of the Committee. He stated that the minutes had been mailed to and noted by the Committee members. He said the minutes were included in the tentative agenda material for the remaining trustees.

A brief discussion ensued concerning estimated ultimate claims incurred during 1991, and the amounts by which this account had been understated through May 31, 1992 for GHMSI International, and National Capital Reinsurance Company. The comment was made that "surprises", whether favorable or unfavorable, should not occur to any significant degree due to monthly updating of the estimated ultimate claims incurred. Mr. Poffenberger said that while that is generally true, even the core Blue Cross and Blue Shield business is subject to the same fluctuations. He explained that a "swing" of only 1% of incurred claims will have a significant impact on staff projections. He said that non-core business was also subject to different trends, and there was a learning curve associated with these different types of risks. Mr. Gamble pointed out that GHMSI International business is not subject to a "3-year cycle" that domestic business seems to be affected by. He reiterated that GHMSI has retained the actuarial consulting firm of Tillinghast to audit the quality work product of International Consulting Services, Inc. (ICS), a wholly-owned subsidiary of GHMSI which develops rates and calculates incurred claims estimates for the International Division and the Insurance Group. Mr. Giuliani added that adjustments to the funds held for the payment of claims must also take into

consideration what our competition is doing in this regard, what adjustments will be acceptable to the marketplace and whether rates necessary to support those adjustments will be approved by the insurance departments.

Following a review of the minutes, it was

VOTED: To approve the minutes of the July 6, 1992 meeting of the Executive Committee as circulated and presented.

MINUTES OF THE MEETING OF THE COMMITTEE ON FINANCE AND INVESTMENT - JUNE 17, 1992

Mr. Harrison, chairman of the Committee on Finance and Investment, presented the minutes of the June 17, 1992 meeting of the Committee. He stated that the minutes had been mailed to and noted by the Committee members. He said that the minutes were included in the tentative agenda material for the remaining trustees.

Mr. Harrison noted that a special meeting of the Committee will be scheduled shortly to consider the appropriateness of the amount and percent of GHMSI's investment in equities. In response to an inquiry, Mr. Giuliani said that approximately 50% of GHMSI's investment portfolio is in equities. Mr. Harrison said, in response to a question, that the Committee has an investment policy in place which it follows.

Following a discussion, it was

VOTED: To accept the minutes of the June 17, 1992 meeting of the Committee on Finance and Investment as circulated and presented.

MINUTES OF THE MEETING OF THE AD HOC BUILDING COMMITTEE - JUNE 25, 1992

Mr. Harrison, chairman of the Ad Hoc Building Committee, presented the minutes of the June 25,1992 meeting of the Committee. He stated that the minutes had been mailed to and noted by the Committee members. He said the minutes were included in the tentative agenda material for the remaining trustees.

Mr. Harrison stated that he was "a little disappointed" in progress to date in achieving the purposes of considering relocation options, and disposition of the 550 12th Street, S.W. Building. In responding to a question, he said that the initial premise and business purposes for this project were still valid.

Following a discussion, it was

VOTED: To accept the minutes of the June 25, 1992 meeting of the Ad Hoc Building Committee as circulated and presented.

MINUTES OF THE MEETING OF THE LONG-RANGE PLANNING COMMITTEE - JULY 1, 1992

Mr. Frey, chairman of the Long-Range Planning Committee, presented the minutes of the July 1, 1992 meeting of the Committee. He stated that the minutes had been mailed to and noted by the Committee members. He said the minutes were included in the tentative agenda material for the remaining trustees.

Mr. Frey noted that the purpose of the meeting was to have McKinsey & Company, Inc. present their findings concerning a review of several GHMSI divisions. He said this consulting firm will continue with similar presentations at a meeting of the Committee on August 3, 1992, from 12:00 to 5:00 p.m., with lunch being served. He said that any member of the board of trustees is welcome to attend this meeting, as well as any future presentations given by McKinsey.

Following a discussion, it was

VOTED: To accept the minutes of the July 1, 1992 meeting of the Long-Range Planning Committee as circulated and presented.

REPORT OF THE CHIEF EXECUTIVE OFFICER

Mr. Gamble then presented the Report of the Chief Executive Officer, copies of which had previously been distributed to the trustees. Supplementing that part of the report pertaining to Directors' and Officers' (D&O) Liability Insurance, Mr. Gamble said that the increase from $10 million to $20 million is applicable on an individual basis and on an aggregate basis. He explained that the additional protection was purchased through Plans' Liability Insurance Company, a wholly-owned subsidiary of participating Blue Cross and Blue Shield Plans, which includes GHMSI. A brief discussion ensued concerning the cost of D&O coverage. There was the sense that a $20 million aggregate was less than adequate for GHMSI's needs. Staff was directed to look into further increasing the D&O coverage with a level of at least $10 million per director and officer without application of the limiting aggregate at $20 million.

Following a discussion, it was

VOTED: To accept the report of the Chief Executive Officer as presented July 14, 1992.

A copy of the Report of the Chief Executive Officer is attached to and made a part of these minutes.

LEGAL COUNSEL'S REPORT

Mr. Steele presented the Legal Counsel's Report, copies of which had been distributed to the trustees with the tentative agenda material.

In response to a question concerning litigation arising from Blue Cross and Blue Shield of West Virginia, Inc.'s liquidation, Mr. Steele said there are no other claims that he is aware of against the officers and directors of the failed Plan, and that the liquidator has the authority to settle all claims. Discussion then followed concerning various allocations of recovery amounts among providers, patients and others. Mr. Steele said he has not seen the final settlement agreement and, therefore, could not elaborate on amounts various claimants may receive.

It was then

VOTED: To accept the Legal Counsel's Report as presented July 14, 1992.

A copy of the Legal Counsel's Report dated July 14, 1992 is attached to and made a part of these minutes.

FINANCIAL REPORT

Mr. Gamble referred to a GHMSI May 1992 year-to-date (consolidated) income statement summary, presented on a generally accepted accounting principles (GAAP) basis, and explained that this summary was presented to the Executive Committee at its meeting held July 6, 1992. He noted that the minutes of that discussion are included under tab 8, and that staff would be happy to respond to any questions the trustees may have. He said that an income statement summary for the month ending May 31, 1992 and an Enterprise reserve statement as of May 1992 were also included with the tentative agenda material for informational purposes.

A discussion followed concerning the estimated loss of $11 million in 1992 for the National Treasury Employees Union (NTEU) account. Mr. Giuliani explained that, as he had previously notified the board and the Executive Committee on several occasions, staff estimates that BCBSNCA will incur an $11 million loss during 1992 and has decided to book that loss throughout 1992. He explained that $3 million of that loss was charged during April, and approximately $1 million will be charged each month throughout the remainder of the year. Mr. Giuliani said these losses will be absorbed, in part, through an estimated $8 million overstatement in the Incurred But Not Reported (IBNR) account as of December 31, 1991. He reiterated that BCBSNCA notified the account that, due to the likelihood of further deterioration of NTEU enrollment, and intended

increasingly higher rates, it would not renew the account for the plan year commencing January 1, 1993. Mr. Giuliani said that staff is still projecting a net income for BCBSNCA for the year of approximately $1.7 million. In responding to the question of why the IBNR was overstated, Mr. Giuliani said it has been staff's practice, historically, to try to protect the Plan by being conservative in its IBNR reporting. Mr. Giuliani stated that the reserve for IBNR has been increased by approximately 25% since May 1991 and now totals approximately $285 million.

Mr. Poffenberger then referred to the GHMSI May 1992 year-to-date consolidated income statement summary and said that the loss of $11.578 million was primarily an operational loss. He explained that if staff projections hold for the remainder of 1992, this loss will be reduced by approximately $8 million from operations on a consolidated basis, but that any such projection excludes estimated losses of approximately $2.5 million from Emtrust, Inc. Mr. Wiggin said he was concerned with the adequacy of reserves on both a GAAP basis and a SAP basis, and that a "surprise" of any magnitude could seriously jeopardize these reserves. Mr. Nason said he had a concern with the percent of GHMSI's portfolio invested in equities. Mr. Poffenberger pointed out that the Committee on Finance and Investment had discussed this matter at its meetings in April and July, and plans to call a special meeting in August to discuss it further. Mr. Gamble said he believes GHMSI's investment policy should reflect the need to keep pace with current economic developments, because our claims are incurred with such volume and in such large amounts, which require prompt payment unlike, for example, the claims of a life insurance company which factor longevity and actuarial considerations expanding a period of years. Mr. Nason said he shared the sense of concern previously expressed about the adequacy of GHMSI's reserves.

Following a discussion, it was

VOTED: To accept the Financial Report as presented July 14, 1992.

A copy of the cover memorandum titled Financial Report dated July 14, 1992 submitted by Mr. Gamble, a Group Hospitalization and Medical Services, Inc. Income Statement Summary (Consolidated) May 1992 YTD, a Group Hospitalization and Medical Services, Inc. Income Statement Summary (Consolidated) for the Month Ending May 31, 1992, and a Group Hospitalization and Medical Services, Inc. Enterprise (Consolidated) May 1992 YTD Results, GAAP Basis is attached to and, by reference, made a part of these minutes.

REPORT ON HEWITT ASSOCIATES' INVESTMENT PERFORMANCE REVIEW - JULY 14, 1992

Mr. Poffenberger presented the Report on Hewitt Associates' Investment Performance Review which had been distributed to the trustees with the tentative agenda material.

Following a discussion, it was

VOTED: To accept the Report on Hewitt Associates' Investment Performance Review as presented July 14, 1992.

A copy of the Report on Hewitt Associates' Investment Performance Review is attached to and made a part of these minutes.

REPORT OF THE TRUSTEES OF THE GROUP HOSPITALIZATION AND MEDICAL SERVICES, INC. PENSION TRUST PLAN FOR THE PLAN YEAR ENDED DECEMBER 31, 1991

Mr. Pace presented the Report of the Trustees of the Group Hospitalization and Medical Services, Inc. Pension Trust Plan for the Plan Year Ended December 31, 1991, which had been distributed to the trustees with the tentative agenda material. Mr. Pace introduced Mrs. Debbie Salinger of BCBSNCA who coordinates Pension Trust Plan activities, and who would assist with any questions of a technical nature dealing with the Pension Trust Plan. Mr. Pace pointed out that, according to GHMSI's actuarial consultant, Foster Higgins, the GHMSI Pension Trust Plan is fully funded and no contribution is required for the 1992 Plan Year. He also noted that if the fund's investment portfolio generates a yield of around 8%, it is probable that funding for the 1994 Plan Year will also be averted. Mr. Pace observed that under Internal Revenue Service regulations, additional contributions to pension funding are not permitted if the fund is adequately funded. Mr. Pace said that a full year's funding for the Pension Trust Plan is currently about $6 million.

The question was asked whether the Pension Trust Fund includes any amount for cost of living increases. Mr. Pace said that management looks at its ability to supplement amounts paid to retirees from time to time, and has made such adjustments several times in the past. Mr. Petersen then recommended that staff consider making cost of living adjustments if the Pension Trust Fund is overfunded. Mr. Gamble said that management has responded with adjustments during some years where inflation was especially high, but that he recommends against cost of living increases on the grounds that they imposed future liabilities that may be difficult to keep up with. Mr. Giuliani further explained that any such prior adjustments have been paid from an operating account, and were made outside the Pension Trust Plan. He added that staff would take the suggestion under advisement.

Following a discussion, it was moved that staff develop a policy which requires an evaluation of the Pension Trust Plan on an ongoing basis to determine if, due to inflationary trends, adjustments to pension payments should be made, and whether the company has the ability to fund any proposed adjustments. Mr. Gamble said he thought that adoption of such a motion would be dangerous, and that the current policy of "no promises and no guarantees" should be maintained. Mr. Giuliani said he would prefer to see the motion revised to give management the flexibility to "consider" an adjustment to supplement pension payments every three years, and to come back to the board during the in-

between years where staff thought that was appropriate. Mr. Gamble said he believes any such proposal should not be based on "inflation". Mr. Wiggin then restated his motion, which was seconded as follows:

> That management adopt a policy which calls for an evaluation of the appropriateness of an increase in payments to eligible beneficiaries from the Pension Trust Fund every three years, given due consideration to the company's ability to fund such additional payments.

Following a vote, which failed by a margin of 8 to 5, with 3 abstentions, Mr. Giuliani said that management understands the concerns of those favoring the motion, and intends to give further consideration to the matter.

Mr. Pace then explained that the Pension Trust Plan trustees had requested Hewitt Associates to recommend additional investment counselors because the market value of pension fund assets, at the time the request was made, exceeded $100 million. He further explained that ASB Capital Management, Inc. is the sole investment counselor for the Pension Trust Plan Fund, and currently controls assets in excess of $120 million. He said that based on Hewitt Associates' proposal, the Pension Trust Plan trustees recommend that the Pension Trust Plan portfolio be separated, effective immediately, with ASB Capital Management, Inc. maintaining control over the Fund's $50 million in fixed income investments, and to select Jundt Associates, Inc. and Cooke & Bieler, Inc. to manage the Fund's equity investments, with current values of $30 million and $40 million, respectively.

A brief discussion ensued with some concern expressed that the recommendation exposed retirees' pension funds to a less conservative investment. Mr. Gamble said he did not view the recommendations as being less conservative, but rather as moving part of the pension fund investments from one investment manager who is not performing all that well to two additional investment managers who are performing exceptionally well. Mr. Poffenberger pointed out that in Hewitt Associates' opinion, the Pension Trust Plan trustees' recommendations do not involve any greater risk.

Following a discussion, it was

> VOTED: To adopt the recommendation of the Pension Trust Plan trustees to separate the Pension Trust Plan portfolio, effective immediately, with ASB Capital Management, Inc. maintaining control over the Fund's $50 million in fixed income investments, and to select Jundt Associates, Inc. and Cooke & Bieler, Inc. to manage the Fund's equity investments, with current values of $30 million and $40 million, respectively; and to accept the Report of the Trustees of the Group Hospitalization and Medical Services, Inc. Pension Trust Plan for the Plan Year Ended December 31, 1991.

A copy of the Report of the Trustees of the Group Hospitalization and Medical Services, Inc. Pension Trust Plan for the Plan Year Ended December 31, 1991 is attached to and made a part of these minutes.

REPORT OF THE EMPLOYEES' THRIFT PLAN ADMINISTRATION COMMITTEE FOR THE PLAN YEAR ENDED DECEMBER 31, 1991

Mr. Pace presented the Report of the Employees' Thrift Plan Administration Committee for the Plan Year Ended December 31, 1991, which had been distributed to the trustees with the tentative agenda material. Supplementing this report, Mr. Pace said that management had made a recent change in the employer's minimum Thrift Plan contribution. He explained that at its January 14, 1992 board of trustees' meeting, the trustees approved a staff recommendation to amend the Plan Document for the GHMSI Employees' Thrift Plan, effective January 1, 1992, "... to allow employers in the GHMSI Enterprise which have adopted the GHMSI Employees' Thrift Plan to make contributions to the Trust on behalf of their eligible participants at a rate from 0% to 10%." Mr. Pace pointed out that this recommendation had the effect of decreasing an employer's contribution from not less than 2.5% to 0%. He explained that while that recommendation was approved, the board of trustees noted that because staff already has the board's authority for a 2.5% employer contribution, no further authorization is necessary should staff later decide to restore the benefit to that level. Mr. Pace said that, due to certain discrimination testing which must be done to assure that Internal Revenue Service regulations have been satisfied, staff has restored the benefit to a minimum employer contribution of one percent. He said that no amendment to the Plan Document is required, and that employers in the GHMSI Enterprise which have adopted the GHMSI Employees' Thrift Plan may make contributions to the Trust on behalf of their eligible participants at the rate of between 0% to 10%. Mr. Pace said that the minimum contribution of 1% was recommended to staff by its consultant as an incentive to help assure an appropriate level of employee participation in the Thrift Plan, without which a passing of the discrimination testing could be in jeopardy. Mr. Pace said this report and supplemental report were for informational purposes of the board.

Following a discussion, it was

VOTED: To accept the Report of the Employees' Thrift Plan Administration Committee for the Plan Year Ended December 31, 1991.

A copy of the Report of the Employees' Thrift Plan Administration Committee for the Plan Year Ended December 31, 1991 is attached to and made a part of these minutes.

PROPOSED CHANGES IN THE GHMSI COMPREHENSIVE HEALTH INSURANCE PLAN

Mr. Pace presented Proposed Changes in the GHMSI Comprehensive Health Insurance Plan, copies of which had been distributed to the trustees with the tentative agenda material. Responding to a question of why the company is recommending that it continue to pay even part of the cost of dependents' coverage, Mr. Pace said that management presently views this as somewhat of a moral commitment to its employees. Referring to the reduction in health care plan contributions for employees with 15 years of pension service who may retire after the "grandfather" period (December 31, 1997), the question was asked how many people are in that category, and whether a large number of valuable employees may leave at that time. Mr. Pace said there are about 75 employees who will fall into that category, and that staff had considered that possibility. He said that no mass exodus of those employees is anticipated. The question was asked whether staff had considered waiving future pay increases so as to be able to maintain the current level of contribution for retirees' dependents. Mr. Giuliani said that while that concept has merit, there are many employees who have self-only coverage and would not be interested in giving up a salary increase in order to help fund coverage for retirees' dependents.

Following a discussion, it was

VOTED: To adopt the staff recommendation that active employee and disabled employee contributions, and retirement eligibility and contributions for the GHMSI Comprehensive Health Insurance Plan be modified as set forth in the report titled Proposed Changes in the GHMSI Comprehensive Health Insurance Plan - July 14, 1992.

Mr. Petersen and Mr. Wiggin voted against the staff recommendation.

A copy of the report titled Proposed Changes in the GHMSI Comprehensive Health Insurance Plan is attached to and made a part of these minutes.

REPORT ON BOARD POLICY

Mr. Gamble presented the Report on Board Policy which had been distributed to the trustees with the tentative agenda material. Mr. Gamble explained that this policy, having to do with GHMSI's long-standing policy avoiding any possible conflict of interest or appearance of impropriety has, to some extent, been documented in GHMSI's records, but he thought that it should be formalized.

Following a discussion, it was

VOTED: To adopt the Report on Board Policy as being reflective of GHMSI's long-standing policy.

Minutes of the Meeting of the GHMSI Board of Trustees - July 14, 1992

A copy of the Report on Board Policy dated July 14, 1992 is attached to and made a part of these minutes.

OTHER BUSINESS

U. S. Senate Permanent Subcommittee Subpoena

Mr. Gamble then provided a brief update on the U. S. Senate Permanent Subcommittee on Investigations, chaired by Senator Sam Nunn, which had subpoenaed GHMSI's records as well as several other Plans and the Blue Cross and Blue Shield Association. He referred to the first hearing held July 2, 1992 which heard testimony from Maryland Insurance Commissioner John Donaho, and D. C. Superintendent of Insurance Robert Willis. He said the next hearing is scheduled for July 29-30, 1992 and will focus on the liquidated West Virginia Plan. Mr. Gamble said staff is interviewing several law firms which specialize in these types of proceedings, and expects to retain one within the next several days. He explained that the scope of the subpoena is exceedingly broad, and that we will attempt to narrow its scope. He said it is management's intent to cooperate fully with the Subcommittee and its staff. He said it is important that this matter be coordinated properly so that GHMSI's business is not damaged through press articles; and that any press inquiries to trustees should be referred to Mr. Raymond Freson, Director, Public Relations and Advertising. Mr. Gamble said he would keep the board fully apprised about this matter, and that presently management has no idea what the Subcommittee might be looking for.

Virginia Audit

Mr. Gamble said the Virginia Bureau of Insurance has been in the process of conducting a full audit of GHMSI following its "target audit" concluded earlier this year. He said he was recently advised by Insurance Commissioner Steven Foster that Bureau of Insurance auditors would be replaced by staff from Ernst & Young, and that GHMSI would have to pay for the audit which is estimated at around $170,000. Mr. Gamble said Mr. Foster wants to clarify an issue having to do with which jurisdiction will regulate GHMSI's investments. Mr. Gamble said he explained to Mr. Foster that GHMSI's Congressional Charter requires that it look to the investment laws of the District of Columbia which are applicable to insurance companies, and that staff has followed those laws which are applicable to life insurance companies for many years. Mr. Gamble said that staff is reviewing this matter, and he intends to provide Mr. Foster with conclusive policy in this regard shortly.

Mr. Gamble said the audit will be primarily of a financial nature. Mr. Poffenberger added that the audit will deal with the years 1988-90, and possibly 1991. He said the scope of the audit encompasses the Enterprise.

ADJOURNMENT

The meeting was adjourned at 6:25 p.m.

GROUP HOSPITALIZATION AND MEDICAL SERVICES, INC.

REPORT OF THE CHIEF EXECUTIVE OFFICER
July 14, 1992

DIRECTORS AND OFFICERS' (D&O) LIABILITY INSURANCE

Staff has taken steps to increase the D&O coverage for trustees from $10 million to $20 million.

HEALTH MANAGEMENT STRATEGIES INTERNATIONAL, INC. (HMSI)

The activities of Dillon, Read & Co. Inc. continue with respect to HMSI, and I expect to give the board an oral report at the board meeting on July 14, 1992.

1992 DIVISION BUSINESS PLANS

Each GHMSI division/group president has prepared a revised 1992 business plan to reflect more current situations and financial forecasts. As part of the process, they have also identified (1) key revenue and expense assumptions, (2) major contingencies which could reduce profits, (3) actions taken to increase 1992 profits, (4) business segment profit analyses, and (5) monthly cash flow forecasts.

Mr. Giuliani and I have met separately with each division/group president to review the material in detail.

The division/group presidents are now preparing similar material for 1992, which Mr. Giuliani and I will review with them on July 14 and July 15.

REPORT OF THE GHMSI CHIEF EXECUTIVE OFFICER - July 14, 1992

This material will also be used in summary form in the meetings GHMSI staff will be having with the staff of the Blue Cross and Blue Shield Association.

ACTUARIAL REVIEW

In view of the number of substantial changes in our actuarial forecasts (see the minutes of the July 6, 1992 meeting of the GHMSI Executive Committee, included under tab 8), I have retained the actuarial consulting firm of Tillinghast to conduct a quality audit of our International Consulting Services, Inc. (ICS) work product.

ICS sets the rates for our International Division products and our National Capital Re products, and also calculates the incurred claims expense for those products.

In addition, the International Division has retained the actuarial consulting firm of The Wyatt Company to review the appropriateness of its rates and claims expense calculations, while the Insurance Group has retained the actuarial consulting firm of Lewis & Ellis to review the appropriateness of its rates and claims expense calculations.

We will be using the advice and counsel of these firms in an effort to improve the quality of our actuarial activity, as well as our underwriting results in the International Division and the Insurance Group.

REPORT OF THE GHMSI CHIEF EXECUTIVE OFFICER - July 14, 1992

NATIONAL CAPITAL ADMINISTRATIVE SERVICES, INC. (NCAS)/AGENCY FOR INTERNATIONAL DEVELOPMENT (A.I.D.)

We have reported to the board in the past on the claims NCAS has filed against A.I.D. and the likelihood of a lawsuit regarding those claims. A report on the current status of that matter is attached to this report.

Respectfully submitted,

J. P. Gamble
Chief Executive Officer

MEMORANDUM TO: J. P. Gamble

FROM: W. G. Hendren W. G. Hendren

SUBJECT: Agency for International Development (A.I.D.)

DATE: July 7, 1992

Proposals have been submitted by both the Justice Department and NCAS for resolution of all outstanding claims between the Government and NCAS in connection with NCAS' contract to administer the Office of International Training Health and Accident (HAC) Program for 1988, 1989, 1990 with two optional years of 1991 and 1992.

After complaining to the A.I.D. Contracts Officer and Technical Manager in 1988 that the scope of the project was considerably wider than the RFP had described, and would be more expensive to administer than the fixed-price contract would reimburse, we were counseled to perform the work and pursue added compensation. We received advice from Hogan & Hartson with regard to compiling claims for equitable reimbursement in situations like ours, and were encouraged to prepare a claim.

NCAS submitted a claim for an equitable adjustment for 1988 in March 1989, and received additional compensation of $321,553 in November 1989. The contract officer, Ed Thomas, who is now deceased, indicated that a similar claim would need to be prepared for 1989. So, in March 1990, we submitted a claim for $194,772 (covering the additional expenses in 1989) and $199,624 prospectively for 1990. (It has never been paid). In 1992, the A.I.D. failed to timely notify NCAS of the intent to exercise the option year, and a separate agreement was then negotiated for six months.

The essence of the NCAS claim is that the work required exceeds the original specifications due to a failure by the A.I.D. to live up to its duties to supply clean data under the contract. The claim amount is based on the best estimate we could make of the extra labor and overhead expense incurred at NCAS due to the deficiencies on the part of A.I.D. Ed Thomas, as well as the Technical Managers, encouraged NCAS to perform the expanded scope of work and submit a claim for reimbursement of the added expense (as opposed to NCAS' restricting the level of work to the literal contract and doing a lower-quality job).

The Justice Department takes the position that NCAS willfully misrepresented the claim to the contract officer. Their theory is that NCAS deliberately low-balled the bid in order to get the award of the contract, and then contrived a rationale for submitting the claim for equitable adjustment. Part of their evidence for this deduction emanates from the admittedly faulty arithmetic that was used in preparing the 1990 claim, in which labor hours were extrapolated inappropriately.

NCAS operated under the belief throughout 1989, 1990 and the first half of 1991 that A.I.D. wanted to settle this claim fairly. However, the retirement of Ed Thomas and the opportunism of the Qui Tam relator altered that perception. The Technical Managers, who to this day profess their satisfaction with NCAS as a vendor, are helpless to intervene now that the Justice Department has accused NCAS of civil fraud.

The Justice Department is essentially self-deluded in this matter. However, by introducing an added risk to GHMSI should the matter proceed to trial and result in contract debarment, they have leveraged their position to extract a settlement.

To summarize, we currently have a $394,396 receivable from 1989 and 1990. The Justice Department proposes not paying that, and additionally fining NCAS $407,000 for the false claim in 1988. 1991 has not been mentioned. NCAS' attorney countered with a settlement offer of $315,000 last week. Therefore the liability is from $709,396 to $801,396 at this time.

The NCAS claims are reasonable and defensible, and the principal government witness (Ed Thomas himself, the only one who could deny that he encouraged this course of action) has died. Nevertheless, litigation carries a potential legal expense of $225,000 and the exposure of GHMSI to the risk of debarment from Federal contracting.

FOLEY & LARDNER

1775 PENNSYLVANIA AVENUE, N.W.
WASHINGTON, D.C. 20006-4680
TELEPHONE (202) 672-5300
TELECOPIER (202) 672-5399
TELEX 904138
WRITER'S DIRECT LINE

WAUKEE, WISCONSIN
ISON, WISCONSIN
ICAGO, ILLINOIS
ALEXANDRIA, VIRGINIA
ANNAPOLIS, MARYLAND
JACKSONVILLE, FLORIDA
ORLANDO, FLORIDA
TALLAHASSEE, FLORIDA
TAMPA, FLORIDA
WEST PALM BEACH, FLORIDA

A MEMBER OF GLOBALEX
WITH MEMBER OFFICES IN
LONDON, ENGLAND
PARIS, FRANCE
BERLIN, GERMANY
STUTTGART, GERMANY
DRESDEN, GERMANY
SINGAPORE
TAIPEI, TAIWAN

TO: Board of Trustees
Group Hospitalization and Medical Services, Inc.

FROM: Charles J. Steele

DATE: June 25, 1992

RE: Legal Counsel's Report

1. West Virginia Litigation: Undersigned counsel has been approached by counsel for one of the underwriters for Lloyds of London in connection with the claim of the court appointed liquidator for Blue Cross and Blue Shield of West Virginia. He advised that Lloyds is putting up the entire amount of its directors and officers liability policy, less legal fees and other expenses already paid, to settle all claims against the Blue Cross and Blue Shield of West Virginia directors. As you know, Joseph P. Gamble, Benjamin W. Giuliani and Simone J. Pace were directors of Blue Cross and Blue Shield of West Virginia.

The liquidator has accepted the offer, except that he wants the individual directors and officers involved to make up the difference between the approximately $835,000 on the Lloyds policy which remains not dispersed and the $1,000,000 face value of the policy. He estimates this comes to approximately $1,700 per director and officer. We have advised Messrs. Gamble, Giuliani and Pace that because they were on the board of Blue Cross and Blue Shield of West Virginia, as part of a preliminary stage of a merger or other arrangement between the two plans, that under the indemnity agreement contained in the GHMSI bylaws they are, in our opinion, entitled to reimbursement for the deductible of approximately $1,700 each.

Counsel for Lloyds of London advised me that on Monday, June 22, 1992, a hearing was held in the Circuit Court for Kanawha County, West Virginia. The hearing was to resolve a dispute between the United Mine Workers (UMW) and other creditors. Until June 22, the UMW had refused to enter into the proposed global settlement.

At the hearing, the dispute was resolved. Circuit Court Judge King indicated he will enter an order earmarking $225,000 of the $835,000 to be contributed by the Lloyds underwriters to the UMW. In return, UMW will enter into the proposed global settlement, meaning that all claimants against the officers and directors will sign off on the settlement. Counsel for Lloyds underwriters are now preparing the agreements. One of Lloyds lawyers told me that the individual directors' share will come somewhere between $1,500 and $1,600. As indicated above, we have advised Messrs. Gamble, Giuliani and Pace that they are entitled to reimbursement under GHMSI's indemnification bylaw.

GROUP HOSPITALIZATION AND MEDICAL SERVICES, INC.

FINANCIAL REPORT
July 14, 1992

The attached May 1992 year-to-date income statement summary was presented and discussed at the Executive Committee meeting held July 6, 1992. The minutes of that discussion are contained under tab 8 of this tentative agenda material.

For your information, also attached is an income statement summary for the month ending May 31, 1992 and an Enterprise reserve statement as of May 1992.

Respectfully submitted,

J. P. Gamble

Group Hospitalization and Medical Services, Inc.
Income Statement Summary (Consolidated)
May 1992 YTD
(Thousands of Dollars)

	BCBSNCA Division	GHMSI Internal Division	Blue Cross of Jamaica	Assurance Services Group	Insurance Group	HMS	Protocol	NCAS	Other (GHMSI Co.'s and ICS)	Enterprise Consolidated Actual	Enterprise Consolidated Forecast
Revenue	669,667	9,267	2,625	26,136	29,237	11,704	16,956	63,582	3,956	844,285	
Forecast	*717,231*	*12,609*	*2,748*	*27,627*	*32,943*	*11,626*	*16,191*	*67,290*	*4,195*		*892,560*
Cost of Benefits/Services	621,303	6,412	2,322	17,684	28,867	280	14,459	51,036	0	744,463	769,926
Administrative Expenses	59,795	3,998	692	11,536	2,734	11,010	3,338	2,702	4,013	100,819	105,600
Operating Income (Loss)	(511)	(3,143)	(169)	(1,384)	(2,164)	414	(1,809)	(156)	(55)	(8,997)	(4,166)
Other Income (Expense)	(4,141)	461	116	900	64	(103)	173	(41)	0	(2,581)	(7,465)
Net Income (Loss)	(4,652)	(2,682)	(73)	(484)	(2,100)	311	(1,636)	(197)	(55)	(11,578)	
Forecast	*(7,532)*	*(208)*	*(66)*	*(1,618)*	*(160)*	*(234)*	*(1,818)*	*(19)*	*19*		*(11,655)*

July 6, 1992

1992-154

Group Hospitalization and Medical Services, Inc.
Income Statement Summary (Consolidated)
For the Month Ending May 31, 1992
(Thousands of Dollars)

	BCBSNCA Division	GHMSI Internat'l Division	Blue Cross of Jamaica	Assistance Services Group	Insurance Group	HMS	Protocol	NCAS	Other (GHMSI Co's and ICS)	Enterprise Consolidated	
										Actual	Forecast
Revenue	129,783	1,726	610	6,856	13,789	2,352	3,183	8,339	757	166,377	
Forecast	*144,874*	*2,851*	*549*	*6,961*	*7,862*	*2,822*	*3,683*	*12,802*	*817*		*191,916*
Cost of Benefits/Services	116,527	2,860	540	3,435	13,029	49	2,794	7,939	0	147,173	159,385
Administrative Expenses	13,269	624	143	2,360	685	2,135	620	466	773	21,295	21,519
Operating Income (Loss)	(13)	(1,958)	(73)	61	55	168	(231)	(66)	(16)	(2,091)	1,011
Other Income (Expense)	(1,074)	171	24	(33)	74	(5)	23	(24)	0	(844)	(1,515)
Net Income (Loss)	(1,087)	(1,785)	(49)	28	129	163	(208)	(110)	(16)	(2,935)	
Forecast	*(304)*	*73*	*(7)*	*(54)*	*(26)*	*4*	*(293)*	*54*	*(3)*		*(504)*

July 6, 1992

GHMSI 23A1 00021

Group Hospitalization and Medical Services, Inc.
Enterprise (Consolidated)
May 1992 YTD Results
GAAP Basis

(Thousands of Dollars)

	Forecast	Actual
Revenue	892,360	844,285
Cost of Benefits/Services	789,928	744,463
Administrative Expenses	106,600	108,819
Operating Income (Loss)	(4,168)	(8,997)
Other Income (Expense)	(7,465)	(2,581)
Net Income (Loss)	(11,633)	(11,578)
Reserves, December 31, 1991		32,442
Decrease in Market Value of Investments		(5,479)
Foreign Currency Translation		-
Reserves, May 31, 1992		15,385
Note: SAP Reserves as of May 31, 1992 (estimated)		58,143

July 6, 1992

GHMSI 23A: 0

1992-155

GROUP HOSPITALIZATION AND MEDICAL SERVICES, INC.

REPORT ON
HEWITT ASSOCIATES' INVESTMENT PERFORMANCE REVIEW
July 14, 1992

In addition to the GHMSI corporate investment portfolio, which is under the direction of the Committee on Finance and Investment, GHMSI also has two other investment portfolios for which it is responsible, i.e., the GHMSI Pension Trust Plan portfolio and the GHMSI Employees' Thrift Plan portfolio. Except for the short-term portion of the GHMSI corporate portfolio which is managed by staff, all other funds are managed by outside investment organizations.

The GHMSI long-term corporate portfolio currently has four investment management firms. ASB Capital Management Inc. and Criterion Investment Management Company manage the fixed-income portion of the portfolio, with market values as of December 31, 1991 of $14.1 million and $15.6 million, respectively. Jundt Associates and Trust Company of the West manage the equity portion of the portfolio, with market values as of December 31, 1991 of $36.3 million and $27.1 million, respectively.

The GHMSI Pension Trust Plan portfolio, valued at $120.2 million as of December 31, 1991, is managed by ASB Capital Management Inc., and the $17.2 million Employees' Thrift Plan portfolio is managed by Dreyfus Management, Inc.

In order to monitor the performance of each of these investment management organizations, GHMSI has selected the firm of Hewitt Associates, a national actuarial firm with headquarters in Chicago, Illinois, to provide comparative investment performance data for these portfolios. The portion

of the Hewitt Associates' report for the year 1991 relative to the performance of the GHMSI corporate portfolio has been reviewed by the GHMSI Committee on Finance and Investment; the Pension Trust Plan portion by the GHMSI Pension Trust Plan Trustees; and the Thrift Plan portion by the GHMSI Thrift Plan Administration Committee. Representatives of the appropriate investment management organizations generally attend each meeting when investment performance is reviewed.

As a matter of policy, each committee responsible for an investment portfolio reviews the annual performance of the portfolio using the Hewitt Associates' data to determine that the total rate of return on the portfolio is reasonable when compared with the performance of other portfolio managers. To assist in this matter, the Hewitt data reflects the percentile ranking of the investment performance for each portfolio, whereby the best performance of the approximately 300 portfolios reviewed by Hewitt in 1991 would fall in the 99th percentile, and the 50th percentile would reflect that one-half of all other portfolios reviewed had better performance. Based upon the 1991 Hewitt report, the comparative portfolio performance for the year 1991 and the cumulative performance for the period indicated are shown on the attached table.

Respectfully submitted,

J. P. Gamble

Attachment

	1991 Rate of Return*	1991 Percentile	Cumulative Rate of Return*	Cumulative Percentile	Cumulative Data Reflects Performance Since:
GHMSI Corporate Fixed Income					
ASB Capital Management Inc.	16.12%	54%	12.69%	86%	April 1, 1983
Criterion Investment Management Company	17.64%	81%	15.05%	93%	July 1, 1981
Equities					
Jundt Associates	65.19%	94%	24.73%	73%	October 1, 1985
Trust Company of the West	31.95%	47%	16.10%	66%	October 1, 1979
GHMSI Pension Trust Plan					
Equity Holdings	26.62%	28%	13.78%	44%	
Fixed-Income Holdings	15.75%	48%	12.26%	99%	
Combined	21.46%	33%	12.74%	64%	January 1, 1977
GHMSI Thrift Plan					
Equity Holdings	29.62%	38%	15.94%	76%	
Fixed-Income Holdings	15.21%	39%	11.95%	25%	
Combined	20.93%	31%	14.14%	60%	January 1, 1981

*Based on total return, which includes interest and dividend income and unrealized gains and losses

GROUP HOSPITALIZATION AND MEDICAL SERVICES, INC.

REPORT OF THE TRUSTEES OF THE
GROUP HOSPITALIZATION AND MEDICAL SERVICES, INC.
PENSION TRUST PLAN
FOR THE PLAN YEAR ENDED DECEMBER 31, 1991
July 14, 1992

The annual report of the trustees of the Group Hospitalization and Medical Services, Inc. (GHMSI) Pension Trust Plan has traditionally been presented in a narrative format. This year, the report is being presented in a tabular format, as shown below, providing the same totals which have, in the past, been reflected in the narrative form.

The following summarizes key items of the funded status of the GHMSI Pension Trust Plan as of January 1, 1992, as compared to January 1, 1991:

	January 1, 1992 (Plan Year Ended 12/31/91)	January 1, 1991 (Plan Year Ended 12/31/90)
Assets		
Market Value	$120,225,702	$101,573,437
Actuarial Value	109,356,515	$ 99,998,369
Net Investment Income	$ 6,133,012	$ 6,260,704
Funding Ratio		
Valuation Actuarial Accrued Liability	$111,600,000	$ 97,900,000
Actuarial Value Assets	109,400,000	100,000,000
Funded Ratio*	98%	102%
FAS 35 Accrued Liability	$ 59,400,000	$ 54,000,000
Market Value Assets	120,200,000	101,600,000
Funded Ratio	202%	188%

* The Funded Ratio represents the extent to which the Actuarial Accrued Liability is funded by assets. The decrease in the Funded Ratio is primarily the result of zero contributions. Investment experience alone does not cover both interest on the Actuarial Accrued Liability and the cost of current benefit accruals. Generally, a plan is considered well-funded if the Funded Ratio is 80% or more.

REPORT OF THE TRUSTEES OF THE GROUP HOSPITALIZATION AND MEDICAL SERVICES, INC. PENSION TRUST PLAN FOR THE PLAN YEAR ENDED DECEMBER 31, 1991 - July 14, 1992

	January 1, 1992 (Plan Year Ended 12/31/91)	January 1, 1991 (Plan Year Ended 12/31/90)
Actual Contributions	$ 0	$ 0
FAS 87 Net Pension Costs	$ 1,918,466	$ 335,021
Participants		
Active Employees	2,951	2,555
Terminated Vested Employees	507	470
Retirees and Beneficiaries	147	144
Disabled Employees	6	6
Total	3,611	3,175
Benefits Paid Out		
Participants	$ 2,555,623	$ 2,473,620
Lump Sums	$ 72,526	16,037
Retirement Benefits Paid from BCBSNCA		
Excess Benefit Plan	$ 67,524	$ 79,225
Corporate Account	14,571	13,400

We have been advised by Foster Higgins, the GHMSI actuarial consulting firm for the GHMSI Pension Trust Plan, that based on current Internal Revenue Service minimum funding regulations, the GHMSI Pension Plan is fully funded and no contribution is required or permitted for the 1992 Plan year. Projections indicate that no contributions will be required for the 1993 or 1994 Plan years; however, slightly adverse experience could result in a contribution requirement for 1994. The 1992 Financial Accounting Standards (FAS) 87 amount is $3,152,837.

REPORT OF THE TRUSTEES OF THE GROUP HOSPITALIZATION AND MEDICAL SERVICES, INC. PENSION TRUST PLAN FOR THE PLAN YEAR ENDED DECEMBER 31, 1991 - July 14, 1992

The Pension Plan Trustees met with a representative of the Plan's investment counselor once during the year to review the cash flow and investment results of the Pension Trust Fund. At the April 22, 1992 meeting, the Trustees met with a representative of Hewitt Associates to review the 1991 annual performance evaluation report prepared by Hewitt for the GHMSI Pension Trust Fund.

In addition, over a year ago, at the request of the Pension Plan Trustees, Hewitt Associates was asked to recommend additional investment counselors since, at that time, the market value of assets of the pension fund exceeded $100 million. At the June 23, 1992 meeting of the Pension Plan Trustees, Hewitt Associates presented its recommendations.

Currently, ASB Capital Management Inc., the sole investment counselor for the Pension Trust Plan Fund, holds assets exceeding $120 million, which includes $68 million in equities and $52 million in fixed-income investments. Hewitt Associates proposed leaving ASB Capital Management Inc. with $50 million in fixed-income investments and assigning the remainder of the portfolio to two equity counselors to be retained. The Pension Plan Trustees considered four equity counselors and decided to leave $50 million in fixed-income investments with ASB Capital Management Inc. and to place $30 million in equity investments with Jundt Associates, Inc. and $40 million in equity investments with Cooke & Bieler, Inc.

REPORT OF THE TRUSTEES OF THE GROUP HOSPITALIZATION AND MEDICAL SERVICES, INC. PENSION TRUST PLAN FOR THE PLAN YEAR ENDED DECEMBER 31, 1991 - July 14, 1992

Staff, therefore, recommends that effective immediately, the Pension Trust Plan portfolio be separated, with ASB Capital Management Inc. maintaining control over the Fund's $50 million in fixed-income investments and to select Jundt Associates, Inc. and Cooke & Bieler, Inc. to manage the Fund's equity investments, with current values of $30 million and $40 million, respectively.

Respectfully submitted,

J. P. Gamble

GROUP HOSPITALIZATION AND MEDICAL SERVICES, INC.

REPORT OF THE
EMPLOYEES' THRIFT PLAN ADMINISTRATION COMMITTEE
FOR THE PLAN YEAR ENDED DECEMBER 31, 1991
July 14, 1992

The GHMSI Employees' Thrift Plan completed 22 years of operation on December 31, 1991, with 2,159 active participants, 181 participants in suspension, and seven retirees and one spouse of a deceased retiree receiving monthly payments from the Plan, representing a total of 2,348 participants. During the year ended December 31, 1991, 275 employees joined the Thrift Plan and 190 participants terminated employment.

Following are the 1991 statistics of the GHMSI Employees' Thrift Plan:

	FUND A (Balanced Fund)	FUND B (Money Market Fund)	TOTAL
Market Value (as of 12/31/90)	$16,059,696	$ 9,201,748	$25,261,444
Company Contributions	$ 1,786,777	$ 1,238,339	$ 3,025,116
Employee Contributions	$ 1,187,670	$ 849,437	$ 2,037,107
Employee Withdrawals	($ 3,979,296)	($ 2,085,656)	($ 6,064,952)
Inter-Fund Transfers	($ 155,389) $ 204,378	($ 204,378) $ 155,389	$ 0
Net Investment Income	$ 3,118,603	$ 550,727	$ 3,669,330
Market Value (as of 12/31/91)	$18,548,311	$10,023,469	$28,571,780
Yield	19.18%	5.74%	N/A

REPORT OF THE GHMSI EMPLOYEES' THRIFT PLAN ADMINISTRATION COMMITTEE
FOR THE PLAN YEAR ENDED DECEMBER 31, 1991 - July 14, 1992

The combined market value of Fund A and Fund B on December 31, 1991 was $28,571,780, reflecting an increase in market value of $3,310,336 for the year.

The Thrift Plan Administration Committee met five times during the year. Beginning June 1, 1991, the Committee ceased reviewing "financial need" withdrawals since, as of that date, "financial need" was no longer required for withdrawals that include eligible funds other than employee contributions. The board of trustees of GHMSI approved this change at its May 5, 1991 meeting. The Committee met in November 1991 with representatives of Dreyfus Management, Inc. and Hewitt Associates to review the Funds' performance.

Respectfully submitted,

J. P. Gamble

GROUP HOSPITALIZATION AND MEDICAL SERVICES, INC.
PROPOSED CHANGES IN THE GHMSI COMPREHENSIVE HEALTH INSURANCE PLAN
July 14, 1992

The Financial Accounting Standards Board (FASB) has adopted a standard, Statement Number 106 (FAS 106), which will require employers to recognize the cost of health and welfare benefits earned by an employee's current service but not paid until after retirement. FAS 106 requires companies to estimate amounts that will be paid in current and future costs, and reflect those costs as a liability on the corporation's balance sheet. The standard provides that past service cost can be amortized over 20 years. The recognition of the cost of post-retirement benefits during employees' working lifetimes will have a significant impact on GHMSI financial statements starting in 1993. Based on actuarial assumptions, the estimated GHMSI Enterprise FAS 106 liability for health care coverage, based on the current retiree benefit of requiring no retiree contribution, is $5.6 million for 1993, with $2.2 million of that amount applicable to current retirees. The estimated actuarially expected post-retirement benefit obligation would be approximately $83 million if a single "up-front" assessment were to be made. The actual liability will be calculated in 1993 based on 1992 claims experience and modified eligibility. The estimated FAS 106 liability for post-retirement life insurance is $270,000 annually.

GHMSI and BCBSNCA have been grappling with the FAS 106 cost issue, as well as the rising cost of health insurance, for several years. This matter was first presented to the board as a future issue during the January 1991 board meeting. In order to reduce the FAS 106 expense, changes to the post-retirement health insurance program must be made.

PROPOSED CHANGES IN THE GHMSI COMPREHENSIVE HEALTH INSURANCE PLAN -
July 14, 1992

Active employees currently do not contribute toward their retiree health insurance coverage. If contributions are required by active employees for the cost of health insurance, revenue would be generated to offset the FAS 106 liability. Also, if future retirees paid for some portion of their health insurance coverage, that would also help to reduce the FAS 106 cost to GHMSI accordingly. The following are recommended changes for active employees, retirees, beneficiaries and disabled employees:

Active Employees

- Currently, most divisions/groups in the GHMSI Enterprise which participate in GHMSI's Comprehensive Health Insurance Plan provide individual and family coverage at no cost to the employee. Effective January 1, 1993, individual coverage only will be provided at no cost to the employee. Also effective January 1, 1993, it is recommended that non-exempt employees pay 40% of the difference between individual and family coverage and exempt employees pay 50% of the difference between individual and family coverage. Based on the current individual and family rates, non-exempt employees would pay $86 per month and exempt employees would pay $108 per month. (This will raise approximately $2.2 million per year, based on 1992 rates, to offset the FAS 106 expense.)

Retirees

- The recommendation for active employees to contribute toward the cost of family coverage does not affect existing retirees, beneficiaries or disabled employees.

- Employees who retire with 15 years or more of pension service in the next five years, i.e., January 1, 1993 through December 31, 1997, will be grandfathered, with fully funded employer health care coverage. The 15-year requirement is an increase from our present 10-year requirement to be consistent with our current early retirement requirement of age 55 with 15 years of pension service. Anyone with less than 15 years of service who retires will be eligible for health insurance under the Consolidated Omnibus Budget Reconciliation Act (COBRA) which provides that departing employees may purchase health benefits from the employer for up to 36 months.

PROPOSED CHANGES IN THE GHMSI COMPREHENSIVE HEALTH INSURANCE PLAN - July 14, 1992

Retirees (continued)

- Effective January 1, 1993, employees who retire with 15 years or more of pension service will receive group life insurance premiums fully funded by the employer. This 15-year requirement is an increase from our present 10-year requirement. If the employee retires after January 1, 1993 with less than 15 years of pension service, a conversion plan for group life insurance is available, which would be fully paid for by the retiree.

- Effective January 1, 1998, it is recommended that all employees who retire with 15 or more years of pension service, be eligible for individual health insurance coverage only, funded by the employer. For family coverage, the retiree will be required to pay the difference between individual and family rates. As is presently required, if any retiree remarries or marries for the first time after retirement, the full cost of dependent coverage will be paid by the retiree.

- These changes are consistent with a philosophy of providing active and retired former employees with benefits, in conjunction with reducing our obligation and expenses for their dependents as a business requirement in response to the FAS 106 liability. The purpose of not commencing retiree contributions for coverage until January 1, 1998 is to provide employees retiring after that date an opportunity to plan to finance their new liability.

Disability

- Any employee who is eligible for retirement in the next five years, i.e., January 1, 1993 through December 31, 1997, having the minimum of 15 years of pension service and age 55, who becomes disabled and is approved through both the National Long Term Disability Program (NLTD) and the GHMSI Pension Trust Plan (PTP) will be grandfathered and will receive individual or family health care coverage fully funded by the employer.

- Effective January 1, 1998, any active employee who becomes disabled and is approved through NLTD and PTP will receive individual coverage only, funded by the employer. Dependent coverage will not be paid by the employer. The disabled employee would pay the full difference between individual and family coverage rates.

PROPOSED CHANGES IN THE GHMSI COMPREHENSIVE HEALTH INSURANCE PLAN -
July 14, 1992

Beneficiaries

- Effective January 1, 1993, if an active employee, who has a family contract and who is vested in the PTP, dies, the dependent(s) covered under that family contract will be eligible to continue group benefits. The dependent(s) would pay the full cost of the health insurance coverage.

- Effective January 1, 1993, if an active employee, who has a family contract but is not vested in the PTP, dies, the dependent(s) covered under that family contract will be eligible to continue health insurance coverage through COBRA, which currently provides group benefits for up to 36 months. The dependent(s) would pay the full cost for health insurance coverage through COBRA.

- Effective January 1, 1998, if a retiree, who retired January 1, 1998 or after, dies, the spouse/dependent will be eligible to remain in the group and continue paying the full cost of the coverage.

- Any retiree who remarries or marries for the first time after retirement pays the difference between the individual and family health insurance coverage. This represents no change in current policy. If the retiree's death precedes that of the spouse, the surviving spouse will be eligible to pay the full cost of health insurance coverage through COBRA, which currently provides benefits for up to 36 months.

- Effective January 1, 1993, if an employee on NLTD dies, the dependent(s) covered under that family contract will be eligible to continue health insurance coverage through COBRA, which currently provides benefits for up to 36 months, paid by the dependent(s). (Any employee on disability approved through both NLTD and PTP will be considered as a retiree for their health care coverage benefits.)

GHMSI/BCBSNCA currently offers active, full-time employees, retirees and disabled employees, fully funded family or individual health insurance coverage. The cost to the Enterprise for health insurance coverage in 1991 was $8,982,795.33. A breakdown of these 1991 expenses are as follows:

PROPOSED CHANGES IN THE GHMSI COMPREHENSIVE HEALTH INSURANCE PLAN - July 14, 1992

BCBSNCA (including retirees, disabled employees, and beneficiaries)	$7,404,870.50
CapitalCare	137,384.72
GHMSI (and trustees)	286,048.81
HMSI	695,636.01
NCIA and AMCAP	60,005.62
POSI	63,826.62
Protocol	115,030.93
WAI	219,992.12
TOTAL	$8,982,795.33

Based on current rates and number of family contracts, the projected revenue associated with the proposed changes resulting from active employee contributions toward the cost of family health insurance coverage would be:

Company	Non-Exempt Employee	Monthly Contribution	Exempt Employee	Monthly Contribution	Total (Annual)
BCBSNCA	711	$86	727	$108	$1,675,944
CapitalCare	65	86	50	108	131,880
GHMSI	16	86	67	108	103,344
HMSI	36	86	141	108	219,888
NCIA/AMCAP*	3	86	14	108	21,240
POSI	0	86	16	108	20,736
Protocol	20	86	21	108	47,856
TOTAL**	851		1,036		$2,220,888

* NCIA and AMCAP currently charge $50 monthly toward the cost of family coverage.

** The statistics for WAI are not included since WAI currently charges its employees the full difference in the individual and family rates.

If the proposed modifications to retiree eligibility for GHMSI's Comprehensive Health Insurance Plan are adopted, the FAS 106 Enterprise expense for 1993 is projected to be reduced from $5.6 million to $4.8 million. Additionally, if the proposed modifications relative to employee contributions are approved, the $2.2 million revenue expected from

active employee contributions will offset the $4.8 million, for a net increase in administrative expense as a result of FAS 106 of $2.6 million for 1993.

In addition to requiring active employee contributions toward the cost of family coverage, and modifying retiree eligibility and contributions, benefits under GHMSI's Comprehensive Health Insurance Plan may also be modified. Proposed modifications, if any, will be presented to the GHMSI board in the fall of 1992 for an effective date of January 1, 1993.

Staff, therefore, recommends that active employee and disabled employee contributions, and retirement eligibility and contributions for the GHMSI Comprehensive Health Insurance Plan be modified as set forth above.

Respectfully submitted,

J. P. Gamble

GROUP HOSPITALIZATION AND MEDICAL SERVICES, INC.

REPORT ON BOARD POLICY
July 14, 1992

It has been a long-standing policy of the board of trustees of GHMSI that it is committed to the practice of avoiding any possible conflict of interest or appearance of impropriety. To some extent, this policy has been documented in the records of GHMSI. To the extent that such a policy has not been formalized in GHMSI's records, let it be known that GHMSI will:

1. Require annual conflict of interest disclosures by all trustees, officers and key employees of GHMSI.

2. Require a formal outside review of any proposed contracts between GHMSI and board members that, individually or through firms with which a board member is affiliated, provides financial benefits. This review will be by an objective third party, usually GHMSI's audit firm. The only exceptions to this policy are participating provider agreements offered to physicians on the board or to hospitals with representatives on the board, and such exceptions shall only be granted if such agreements are identical to others offered to the provider community.

3. Any outside review will consider the decision process, contract terms and other issues that may be pertinent in

assuring that GHMSI's interests are not compromised and are conducted at "arm's length".

Respectfully submitted,

J. P. Gamble

National Alliance of Postal and Federal
1628 · 11TH STREET, N.W. • WASHINGTON, D.C. 20001
HOME OFFICE
ORGANIZED OCTOBER 6, 1913
LOCALS IN THIRTY-SEVEN STATES, DISTRICT OF COLUMBIA & THE VIRGIN ISLANDS

Senate Permanent Subcommittee on Investigations
EXHIBIT # 55

JAMES M. McGEE, President
CHARLES J. DENSON, JR., 1st Vice President
WYATT C. WILLIAMS, 2nd Vice President
WILBUR L. DUNCAN, Secretary
LOUIS BLACKMON, JR., Treasurer-Comptroller

OFFICE OF THE PRESIDENT
202-939-6325
FAX 202-939-6389

JACQUELYN C. MOORE, Editor
PRESIDENTIAL AIDES
COMER CASH
LARRY D. LINDSEY
EUGENE A. BROCKINGTON

January 15, 1993

Mr. Gene Richardson, Investigator
Permanent Subcommittee on Investigations
United States Senate
100 Russell Building
Washington, D.C. 20510

Dear Mr. Richardson:

As per our telephone discussion, herewith is the data requested.

The numbers presented are cumulative and unverified for the years 1989-1992.

Monies Paid To BCBSNCA

Administrative Expenses - $17,663,002.00
Service Charge - $ 1,807,500.00

These amounts paid are currently subject to negotiations concerning performance and verification of expenditures.

Sincerely,

James M. McGee
National President

JMM:jhg

National Alliance of Postal and Federal Employees

1628 · 11TH STREET NW • WASHINGTON DC 20001

HOME OFFICE

ORGANIZED OCTOBER 6, 1913

LOCALS IN THIRTY-SI & 7

Senate Permanent Subcommittee on Investigations

EXHIBIT # 56

JAMES M. McGEE, President
CHARLES J. DENSON, JR., 1st Vice President
WYATT C. WILLIAMS, 2nd Vice President
WILBUR L. DUNCAN, Secretary
LOUIS BLACKMON, JR., Treasurer-Comptroller

OFFICE OF THE PRESIDENT
202-939-6325
FAX 202-939-6389

JACQUELYN C. MOORE, Editor
PRESIDENTIAL AIDES
COMER CASH
LARRY D. LINDSEY
EUGENE A. BROCKINGTON

January 15, 1993

Mr. Gene Richardson
Investigator
Permanent Subcommittee on Investigations
United States Senate
100 Russell Building
Washington, D.C. 20510

Dear Mr. Richardson:

In response to your recent inquires as to the relationship between BCBSNCA and the Alliance Health Benefit Plan, we believe some background information may be helpful. Our organization has sponsored a health plan in the FEHB program for over 27 years. All but the last four years we were underwritten by Mutual of Omaha. In 1988 we obtained the services of BCBSNCA for the 1989 plan year.

From its inception, we were troubled by the manner in which BCBSNCA did business. First we were told that BCBSNCA needed "start up cost" in excess of over a million dollars and that its necessary administrative expenses would be well in excess of that paid to Mutual of Omaha. We were not informed of this until after we agreed to accept them as an underwriter and negotiations were complete on the benefit package for the upcoming year. BCBSNCA threatened to terminate the relationship unless their demands were met. With little time left to obtain another underwriter, NAPFE and OPM agreed to the demands. Since that time, the list of problems with BCBSNCA's administration of our programs continued to grow.

Recently, after it had offered to underwrite the plan for 1993, BCBSNCA withdrew that offer in August on the eve of the deadline for finalizing all negotiations for the upcoming year. At the same time it refused to provide us the necessary claims data to solicit bids from other underwriters. We believe this was done because we had refused to agree to an administrative contract that had not been reviewed by OPM and that would have granted BCBSNCA complete access and control of all plan funds and administrative duties. Also, NAPFE would have been precluded from contact and communications with OPM

without BCBSNCA knowledge.

A brief summary of the performance problems we experienced with BCBSNCA operations and personnel which may have contributed to their decision not to underwrite the plan was:

* A refusal to address OPM required agreements which covered in part its obligations as an underwriter.

* Lack of candor concerning admitted errors in administering our drug claims last year which resulted in threats of suits from the waiver of benefits to address the problem. The problems arose because of mistakes BCBSNCA made in our brochure language and claims administration. When the mistakes were discovered, BCBSNCA refused to provide NAPFE with information concerning the financial impact of the errors for nearly a year. It is estimated that we lost about 10,000 members as a result of these mistakes.

* A refusal to review our proposals for administrative expenses.

* A refusal to provide timely financial reports required for OPM submission.

* Less than adequate preparation of required forms for claims information. (See enclosed example of quality assurance form.)

* Delay in brochure preparation and mailing which resulted in not having brochure ready in time for open season.

* Refusal to send representatives to Health Fairs.

* Refusal to consider PPO service for our members even though PPO service is offered by the Blue Cross organization as our competitor.

* Refusal to provide claims information necessary for utilization review, benefits negotiations and soliciting bids from other underwriters.

* Refusal to provide documentation and justification for claimed administrative expenses.

I hope this information is useful. If you have any further questions, please feel free to call.

Sincerely,

James M. McGee
National President

JMM:jhg

Attachment

Senate Permanent Subcommittee
on Investigations
EXHIBIT # 58

CHECK NUMBER
528704

Blue Cross and Blue Shield of the National Capital Area
550 12th Street, S.W.
Washington, D.C. 20065

03006741

PAY TO THE ORDER OF:

MARY K CRADDOCK MD
DOCTOR # 6379

MO	DAY	YR
09	17	92

62-38 311

AMOUNT $ ********542.58

EXACTLY FIVE HUNDRED FORTY-TWO AND 58/100 DOLLARS

CDA NUMBER 200564156

Bankers Trust (Delaware)
Wilmington, Delaware
In Cooperation With
CRESTAR BANK N.A.
Washington, DC

*** NOT VALID OVER $600 *** 92 052 18 0155

Not Valid After 6 Months

AUTHORIZED SIGNATURE

⑈03006741⑈ ⑆031100380⑆ 00564156⑈ ⑈00000542⑈

MARYLAND NATIONAL BANK
REGION 001

	CODE	AMOUNT
	NSF	542.58
	TOTAL	542.58

THIS TOTAL WILL ALSO APPEAR ON YOUR MONTHLY STATEMENT

THE ATTACHED ITEM(S), RETURNED TO US UNPAID, WERE CHARGED TO YOUR ACCOUNT ON

DATE	ACCOUNT
10-29-92	1113281

MARY K CRADDOCK MD
5514 WESTERN AVE
CHEVY CHASE MD 20815

CODE

ACL - ACCOUNT CLOSED	RTM - REFER TO MAKER
DTE - DATE	SIG - SIGNATURE
END - ENDORSEMENT	STP - STOP PAYMENT
NSF - NON-SUFF FUNDS	UNC - UNCOLLECTED FUNDS
OTH - OTHER	

JD1-147 REV 12/91

CUSTOMER COPY

VIRGINIA GOLD CUP ASSOCIATION

The Virginia Gold Cup Races
First Saturday in May

The International Gold Cup Races
Third Saturday in October

December 18, 1992

Mr. John F. Sopko
Deputy Chief Counsel
Permanent Subcommittee on Investigations
Committee on Governmental Affairs
United States Senate
Washington, DC 20510-6250

Dear Mr. Sopko,

In response to your letter on December 9th, I thought it might be helpful to include a narration of our dealing with Protocol, along with the underlying documents.

Our first contact was in the summer of 1990 when Mr. Andrew Stefanovich of Standing Room Only, a firm engaged by the Virginia Gold Cup Association to market tents and sponsorships, signed Protocol to a hospitality tent for $4,000.00. At the time of contracting for the tent Protocol enquired if a race sponsorship where available. As it happened, a race sponsorship was open and Protocol signed a new contract for sponsorship of a race which superseded its corporate tent agreement. Protocol paid with a check of $10,000.00 dated August 24, 1990.

Apparently the race sponsorship and hospitality was very popular with Protocol's customers and guests. On December 19th Protocol signed a two year contract for $20,000.00 per year for a somewhat more prestigious race and larger hospitality tent. The sponsorship proceeded normally in 1991 and we again understood that Protocol's customers where very pleased.

In the summer of 1992 aware of the marketing success of Protocol's sponsorship The Virginia Gold Cup Association again proposed that Protocol upgrade its participation by sponsoring the feature race, The International Gold Cup. On June 17th Protocol responded that budget constraints precluded a change.

The Association Office, P.O. Box 840, Warrenton, VA 22186 (703) 347-2612 Fax - (703) 349-1829

The Course Office, Rt. 2, Box 70, The Plains, Va. 22171 (703) 253-5001 Fax - (703) 253-5005

Sometime in July Race Chairman Langhorne Bond received a call from Ms. Anne Brunst (formally Anne DeEdwardo) that Protocol had not budgeted for the 1992 event and would not participate. Mr. Bond then reviewed the contract and other circumstances to formulate an appropriate response. The sponsorship contract had no provision for cancellation; Protocol was locked in. Although the newspapers had by then published the financial circumstances of the Maryland and DC Blue Cross Health Insurance Plans, there was no mention of any financial difficulties at Protocol. Protocol was not in Chapter 11 and was a going business paying its bills. Accordingly, The Virginia Gold Cup Association was unwilling voluntarily to release Protocol from its contract thereby in effect making a gift of $20,000.00 from its charities to Protocol. Protocol was notified by a letter.

Shortly thereafter Protocol notified The Virginia Gold Cup Association that another firm, USA Healthnet of Phoenix, AZ, would assume the sponsorship. All publicity, banners, etc., where prepared for USA Healthnet. Sponsorship payment was received from Protocol, according to the contract.

Finally, we have had no contact with the other subsidiaries of National Capital Blue Cross listed in your letter.

Sincerely,

Diane Jones
Executive Director

Enclosures: 10

CC: Langhorne Bond
Melville Church, III

CONFIDENTIAL

1991 DIRECTORS AND OFFICERS COMPENSATION**

GHMSI

OFFICERS		DIRECTORS	FEES	OTHER
R. W. BLOSSE'	144,909.22	C. G. CHAPMAN	11,900.00	
G. A. BROWN	197,190.12	C. P. DUVALL, M.D.	27,300.00	
R. A. COOK	194,851.54	R. W. FREY	10,800.00	
R. L. CUNNINGHAM	150,779.46	J. P. GAMBLE	0.00	
G. T. ECKER	125,342.44	T. P. HARRISON	13,300.00	
S. EDELSTEIN	231,239.07	* G. W. JONES, M.D.	9,400.00	1,197.50
J. P. GAMBLE	533,899.18	I. LASTER, JR.	12,600.00	
B. W. GIULIANI	463,446.80	P. D. LENARD, M.D.	13,000.00	
R. B. GROPPE	203,950.93	R. C. MAYER	11,400.00	
W. G. HENDREN	183,100.12	# F. D. MCKENZIE	400.00	
R. J. HUBER	171,501.93	V. E. MILLAR	14,100.00	
J. P. KAHL	202,985.09	C. T. NASON	3,900.00	
J. D. KARABIN	152,074.86	L. F. PARKER	12,300.00	
D. H. KESTEL	238,157.22	B. S. PECSON, M.D.	11,800.00	
J. KLEH	165,953.74	* R. E. PETERSON	14,000.00	
P. R. KONGSTVEDT	289,210.54	J. E. SUMTER, JR.	8,200.00	
S. L. KOUSIN	129,887.10	M. WALKER	11,900.00	
M. F. LONG	207,161.04	D. S. WIGGINS	15,300.00	
G. K. MORRIS	116,388.33	L. W. ZAJAC	12,400.00	
S. J. PACE	308,052.86		213,200.00	
W. B. POFFENBERGER	204,883.44			
H. W. RILEY	203,116.80			
E. S. SHIELDS	199,886.16			
S. SIEVERTS	160,825.86			
E. P. VON HOENE	161,134.22	* NOT ON GHMSI BOARD A/O 12/31/91		
J. H. WALLER	176,577.06	# ON BCBSNCA BOARD ONLY		
	5,491,830.15			

ACCESS AMERICA

J. ANSELL	50,769.24
B. GODLIN	63,392.49
	114,161.73

AMERICAN CAPITAL

G. S. JOHNSON	54,900.80

BLUE CROSS OF JAMAICA *

H. LOWE	42,745.00	L. P. KNIGHT	1,500.00
N. STEWART	29,679.00	U. H. SALMON	1,500.00
A. STEWART-GAYNOR	21,347.00		
	92,771.00		

* REPORTED IN JAMAICAN DOLLARS – CONVERSION RATE USED 12.28:1

ADDITIONAL BENEFITS FOR GHMSI CORPORATE OFFICERS/DIRECTORS

In addition to receiving salary, incentives, and the standard employee benefits, GHMSI corporate officers (Blosse, Brown, Cook, Cunningham, Ecker, Gamble*, Giuliani, Groppe, Hendren, Huber, Kahl, Karabin, Kestel*, Kleh**, Kongstvedt, Kousin, Long, Lowe, Morris, Pace, Poffenberger**, Riley**, Shields, Sieverts, Von Hoene, Waller and Ward) are also offered the following additional benefits:

1. Standard officer benefits:

   a. Long-term disability insurance with coverage at 80% of compensation (salary and incentive);

   b. Personal liability insurance at $5M for senior officers and $3M for other officers to protect against personal loss as a result of legal exposure;

   c. Physical exams mandatory annually for officers 50 years of age or older and mandatory biannually for officers under 50 years;

   d. Split-dollar life insurance for senior officers in the amount of $500,000 and other officers in the amount of $300,000 where, upon death, the corporation and the officer's beneficiary share equally in the proceeds over a two year period.

2. Optional officer benefits - Senior officers are currently allowed $13,700 and other officers are allowed $11,000 and are given a selection of items for which such compensation may be used:

   a. Supplemental life insurance;

   b. Financial planning services;

   c. Tax preparation services;

   d. Medical expense reimbursement;

   e. Club membership;

   f. Car allowance;

   g. Deferred compensation.

   [Note: The money which has been used by the officers for options "a." through "f." is taxed and appears on the compensation chart which has been prepared under the heading "Exec Fringe Benefit"]

* retired
** resigned

3. Supplemental pension benefits - Excess benefit agreements were entered into with select senior officers (Cook, Gamble*, Giuliani, Kestel*, Pace, and Poffenberger**) for supplemental pension benefits payable upon retirement or death in accordance with a base amount established in 1986 and increased by an inflation rate of 7% per annum compounded annually.

4. Company cars are provided for senior vice presidents and the heads of profitable subsidiaries (Cook, Gamble*, Giuliani, Kestel, Kongstvedt, Long, Pace, Poffenberger**, and Shields).

5. Car phones are provided certain for officers/directors for whom there is a business need.

6. Corporate credit cards are held by certain officers/directors for whom there is a business need:

   a. Texaco gas credit card (Gamble*, Giuliani, Kestel*, Long, Pace, and Poffenberger**)

   b. Exxon gas credit card (Cook, Gamble*, Giuliani, Kestel*, Kongstvedt, Long, Pace, and Poffenberger**)

   c. Amoco gas credit card (Gamble*, Giuliani, Kestel*, Kleh**, Kongstvedt, and Long)

   d. AT&T calling card (Blosse, Brown, Cook, Cunningham, Ecker, Gamble*, Giuliani, Groppe, Hendren, Howard, Huber, Kahl, Karabin, Kestel*, Kongstvedt, Kousin, Lowe, McKenty, Morris, Pace, Riley**, Sievarts, Von Hoene, and Waller)

   e. AVIS Rent-a-Car (Blosse, Cook, Crowley***, Gamble*, Giuliani, Groppe, Hendren, Kahl, Karabin, Kestel*, Kousin, and Riley**)

   f. American Airlines Air Travel Card (Blosse, Gamble*, Giuliani, Groppe, Hendren, Kahl, Karabin, Kestel*, McKenty, Pace and Riley**)

   g. Annual fees are paid for personal credit cards which are maintained by officers/directors and for which there is a business need, with an annual fee amount of up to $55 per year (Cook, Crowley***, Cunningham, Edelstein, Gamble*, Giuliani, Hendren, Kahl,

* retired
** resigned
*** terminated

Karabin, Pace, Kongstvedt, Kestel*, Kreager, Middleton, Morrone, Sieverts, Von Hoene, Waller, Ward, and Weimer***)

7. The corporation maintains 10 memberships at the City Club, currently assigned to Brown, Ecker, Giuliani, Groppe, Kahl, Pace, Kongstvedt, Long, Morris, and Ward. In prior years, the company has paid for partial initial membership fees or partial dues for membership in business and/or country clubs (Giuliani, Kleh**). The corporation will also pay for membership in one (1) airline travel club for officers for whom there is a sufficient amount of domestic business travel, and two (2) travel clubs for officers for whom there is a sufficient amount of international business travel.

8. All officers are provided free parking in the corporation's building garage.

In addition to receiving compensation in the form of a retainer and for attendance at meetings, GHMSI board members are also offered supplemental health insurance coverage secondary to their primary health insurance coverage.

* retired
** resigned
*** terminated

LEADERSHIP CONFERENCE DATA

Year	Location	Trip Dates	Trip Cost	Reported Sales *	# of Participants
1992	Monterey, California	4/29/92 - 5/03/92	$392,902	$108,802,321	127
1991	Algarve - Estoril, Portugal	5/13/91 - 5/19/91	$340,387	$164,473,971	111
1990	Naples - Orlando, Florida	3/14/90 - 3/18/90	$302,049	$91,029,733	104
1989	Castle Harbour, Bermuda	4/23/89 - 4/27/89	$242,952	$120,813,838	104
1988	Killarney - Dublin, Ireland	5/13/88 - 5/19/88	$177,063	$58,926,417	71
1987	Casa De Campo, Dominican Republic	2/17/87 - 2/22/87	$85,396	$38,523,503	47

* Reflects life and health sales recorded by Conference participants.

Leadership Conference Participants
Casa De Campo, Dominican Republic
February 17 - 22, 1987

Brian, V. and guest
Duggin, A. and guest
Frakes, D. and guest
Freemen, R. and guest
Gamble, J. and guest
Giuliani, B. and guest
Kecman, F. and guest
Kestel, D. and guest
Knott, P. and guest
Kousin, S. and guest
McPhaul, G. and guest
Miller, J. and guest
Parker, M. and guest
Phillips, A. and guest
Poole, G. and guest
Rand, C. and guest
Ryan, B. and guest
Sayles, L.
Sigmund, D. and guest
Sommer, R. and guest
Subramaniam, C. and guest
Tallent, R. and guest
Tarut, P. and guest
Valentine, V. and guest

Leadership Conference Participants
Kilarney - Dublin, Ireland
May 13 - 19, 1988

Belinkie, J. and guest
Brian, V. and spouse
Brown, G. and spouse
Coad, T. and guest
Cushman, D. and spouse
Frakes, D. and spouse
Gamble, J. and spouse
Giuliani, B.and spouse
Graves, E. and guest
Greer, S. and spouse
Herndon, G. and spouse
Kecman, F. and spouse
Kestel, D. and spouse
Keys, K. and guest
Mahoney, S.and spouse
Mazzerino, R. and spouse
McPhaul, G. and spouse
Miller, J. and spouse
Murray, O. and guest
Neofes, M. and guest
Parker, M. and spouse
Phillips, A. and spouse
Poole, G. and spouse
Rand, C. and guest
Reise, D. and spouse
Ryan, B. and spouse
Sayles, L.
Schleifer, D. and spouse
Sigmund, D. and spouse
Sommer, R. and spouse
Tallent, R. and spouse
Tarut, P. and guest
Thorne, S. and spouse
Valentine, V. and guest
Wester, S. and spouse
Wigfall, C. and spouse

Leadership Conference Participants
Castle Harbor, Bermuda
April 23 - 27, 1989

Barnes, P. and guest
Bedsole, G. and spouse
Belinkie, J. and spouse
Biamonte, F. and spouse
Bogart, W. and spouse
Brown, G. and spouse
Coad, T. and spouse
Conyers, L. and spouse
Dodd, B. and spouse
Dorman, S. and spouse
Flickinger, M. and spouse
Frakes, D. and spouse
Freeman, R. and spouse
Gamble, J. and spouse
Giuliani, B. and spouse
Graham, G. and spouse
Herndon, G. and spouse
Hester, L. and spouse
Homar, S. and spouse
Huber, R. and guest
Kahl, J. and spouse
Kecman, F. and spouse
Kestel, D. and spouse
Long, C. and spouse
Long, M. and spouse
Mahoney, S. and spouse
Mathis, M. and spouse
McGee, C. and spouse
McPhaul, G.and spouse
Miller, J. and spouse
Miller, B. and spouse
Murray, O. and guest
Neofes, M. and guest
Ortt, D. and guest
Pace, S. and spouse
Parker, M. and spouse
Phillips, A. and spouse
Poole, G. and spouse
Rand, C. and guest
Ryan, K. and spouse

Leadership Conference Participants (cont'd)
Castle Harbor, Bermuda
April 23 - 27, 1989

Sommer, R. and spouse
Sprague, M. and spouse
Subramaniam, C. and spouse
Summy, J. and spouse
Tallent, R. and spouse
Tarut, P. and guest
Thorne, S. and spouse
Voorhees, S. and spouse
Waller, J. and spouse
Werber, B. and spouse
Wester, S. and spouse
Wigfall, C. and spouse

Leadship Conference Participants
Naples - Orlando, Flordia
March 14-18, 1990

Akhtar, H. and spouse
Barnes, P. and guest
Belinkie, J. and spouse
Board, H. and guest
Bogart, B. and spouse
Brisco, C. and guest
Brown, G. and spouse
Bundy, S. and spouse
Chase, L.
Coad, T. and spouse
Connelly, J. and spouse
Conyers, L. and spouse
Daly, B. and spouse
Denny, A. and spouse
Duvall, S. and spouse
Fawharger, V.
Frauwirth, B.and spouse
Gould, D.
Guiliani, B. and spouse
Herndon, G. and spouse
Hester, L. and spouse
Hoffman, F. and spouse
Huber, R.
Kahl, J. and spouse
Kestle, D. and spouse
Keys, K.
Kim, G. and guest
Kregar, D. and spouse
Long, M. and spouse
Mahoney, S. and spouse
Mathis, M. and guest
McCall, M. and spouse
McGill, D. and guest
McLeory, J.
McMillian, L. and spouse
McPhaul, G. and spouse
Milano, M.
Miller, J. and spouse
Orem, C.
Pace, S.
Phillips, A. and spouse
Poole, G. and spouse

Leadship Conference Participants (cont'd)
Naples - Orlando, Flordia
March 14-18, 1990

Powell, K.
Rand, C. and guest
Rein, M. and spouse
Renton, R.
Riley, H. and spouse
Ryan, K. and spouse
Schleifer, D. and spouse
Sprague, M. and spouse
Subramaniam, C.
Tallent, R. and spouse
Tarut, P. and guest
Valli, L. and guest
Weiss, R. and spouse
Wigfall, C. and spouse
Wittrock, P. and guest
Yelverton, P. and spouse

Leadership Conference Participants
Algarve - Estoril, Portugal
May 13 - 19, 1991

Adams, K. and spouse
Aktar, H. and spouse
Armand, G. and spouse
Barnes, P. and guest
Board, H.
Brisco, C.
Brown, G. and spouse
Brundred, B. and guest
Bundy, S.
Burke, T.
Chaula, M. and spouse
Coad, T. and guest
Connelly, J. and spouse
Daly, D. and guest
Denny, A. and spouse
Donahoe, M. and spouse
Fleig, Cynthia and spouse
Frakes, D. and spouse
Fyfe, S. and spouse
Gamble, J. and spouse
Guiliani, B. and spouse
Hall, M. and spouse
Hamilton, S. and guest
Hart, R. and spouse
Hayden, B. and guest
Herndon, G. and spouse
Hester, L. and spouse
Huber, R. and guest
Jolles, B. and spouse
Kahl, J. and spouse
Keefer, K.
Kestel, D. and spouse
Keys, K. and guest
Kongstevdt, P. and spouse
Long, M. and spouse
Marshall, D. and spouse
McCall, M. and guest
McGill, D.
Miller, J. and spouse
Murphy, K. and spouse
Pace, S. and spouse

Leadership Conference Participants (cont'd)
Algarve - Estoril, Portugal
May 13 - 19, 1991

Phillips, A. and spouse
Poffenberger, W. and spouse
Rand, C. and guest
Rein, M
Riley, H. and spouse
Ryan, B. and spouse
Schleifer, D. and guest
Seaton, R. and guest
Smithheisler, P. and spouse
Sommer, R. and spouse
Sprague. M. and spouse
Tallent, R. and spouse
Thorne, S. and spouse
Tickson for Hoffman and spouse
Vincent, E.
Waller, J. and spouse
Webb, S.
Wester, S. and spouse
Wittrock, P. and guest

Leadership Conference Participants
Monterey, California
April 29 - May 3, 1992

Adams, Starla and spouse
Alderman-Woods, Alisa and guest
Baiamonte, Frank and spouse
Begley, Jim and spouse
Belinkie, Jon and spouse
Bell, Kavin and spouse
Board, Howard
Bonnet, John spouse
Brick, Paul and spouse
Brisco, Cheryl and guest
Brown, Bonita and guest
Brown, George and spouse
Bryant, Camille
Bundy, Sharon
Burke, Terry
Coad, Tim and spouse
Collins, James and spouse
Conyers, Laura and spouse
Cosby, Ruby and guest
Cox, Gloria
Dale, Richard and spouse
Denny, Anne and spouse
Deyhle, Kenneth and spouse
Donahoe, Mike and spouse
Frakes, Danial and spouse
Freeman, Becky and guest
Gamble, J. and spouse
Gooden, Thersa and guest
Guiliani, Ben and spouse
Hamilton, Susan and guest
Harvey, Maureen and spouse
Hester, Linda and spouse
Hutton, Christpher and spouse
Iarossi, Corte and spouse
Kahl, John and spouse
Keller, Ed and spouse
Kestel, Dave and spouse
Keys, Kathryn and guest
Kongstevdt, Peter
Lembo, Richard and spouse
Lemons, Carolyn

Leadership Conference Participants (cont'd)
Monterey, California
April 29 - May 3, 1992

Marshall, Daryl and spouse
Mathis, Murial and guest
McGill, Dorothy and guest
Miller, John and spouse
Murphy, Kevin and spouse
Pace, S. and spouse
Pal, Mintu and spouse
Peters, Linda and spouse
Phillips, Al and spouse
Rand, Carolyn and guest
Rein, Mac
Riley, Hollins and spouse
Rogers, Gary (for Sigmund) and spouse
Ryan, Kathleen and spouse
Samengo Turner, Keith
Schleifer, Doug and spouse
Subramaniam, C. Shekar
Tallent, Robert and spouse
Tarut, Pam and guest
Thompson Jr., Ed and guest
Thorne, Sandy and spouse
Waller, J. and spouse
Ward, David and spouse
Wester, Sandy and spouse
White, Ron
Wigfall, Cheryl and spouse
Williams, Will and spouse
Yelverton, Peter and spouse

Senate Permanent Subcommittee on Investigations
EXHIBIT # 68

GHMSI & SUBSIDIARIES' CLUB MEMBERSHIPS
11-88 - 1992

Academy of Health Services Marketing
Academy of Medicine
Actuarial Club of Washington
Advertising Club of Washington
Alexandria Chamber of Commerce
Alexandria Medical Society
American Association of International Education
American Association of Occupational Health Nursing
American Association of Preferred Provider Organizations
American Academy of Actuaries
American Airlines' Admirals Club
American Bar Association
American Club
American College of Healthcare Executives
American College of Healthcare Executives' Women's Forum
American College of Physicians
American College of Physician Executives
American Compensation Association
American Corporate Counsel Association
American Diabetes Association
American Guild of Patient Account Management of the National Capital Area
American Health Consultants
American Health Planning Association
American Hospital Association
American Institutes of Certified Public Accountants
American Managed Care & Review Association
American Management Association
American Marketing Association
American Medical Association
American Medical Peer Review Association
American Nurses Association
American Payroll Association
American Psychological Association
American Public Health Association
American Society for Personnel Administrations
American Society for Quality Control
American Society for Training
American Society for Training & Development
American Society of Associate Executives
American Society of Chartered Life Underwriters & Chartered Financial Consultants
American Society of Internal Medicine
American Society of International Medicine
American Society of Notaries
American Society of Travel Agents

Arlington Chamber of Commerce
Association for Computer Training & Support
Association for Computer Operations Management
Association for Corporate Growth
Association for Information & Image Management
Association for Health Services
Association for Supervision & Curriculum Development
Association for Systems Management
Association of Employee Assistance Program Practitioners
Association of Health Care Administrators
Association of Information Systems Professionals
Australian Airlines Flight Deck
Australian Customer Service Association
Australian Institute of Company Directors
Australian Institute of Management
Australian Marketing Institute
Australian Medical Association, New South Wales
Australian Telemarketing Association
Aviation Medical Society

Baltimore-Washington Information System Educators, Inc.
Better Business Bureau of Metropolitan Washington
Blue Cross & Blue Shield Association
Black Human Resources Network

Capital Area Society for Health Care Planning & Marketing
Capital Home Health Association
Capital Services Corporation
Capital Society for Planning & Marketing
Caribbean Hotel Association
Central Fairfax Chamber of Commerce
Chartered Institute of Marketing
City Tavern
City Club of Washington

D.C. Chamber of Commerce
Data Administration Management Association
Data Processing Management Association
Delta Airlines Crown Room
Development Center Institute
District of Columbia Association of HMO's
District of Columbia Bar
District of Columbia Hospital Association
District of Columbia Life Underwriters Association
District of Columbia Medical Group Management Association
Duke University Health Care Alumni Association

Economic Club of Detroit

EDP Auditor's Association
EDP Roundtable
Employer's Council on Flexible Compensation

Fairfax County Chamber of Commerce

Fairfax County Medical Society
Fairfax Hospital Medical Staff
Federal Bar Association
Federal City Council
Financial Executives Institute
Financial Management for Data Processing
Friends of the Kennedy Center

Greater Washington Research Center
Group Health Association of America, Inc.
Group Underwriters Association of America
Guide International

Healthcare Financial Management Association
Hospital Council of the National Capital Area

Individual Case Management Association
Institute for Behavioral Healthcare
Institute of Chartered Accountants of Jamaica
Institute of Industrial Engineers
International Association of Business Communicators
International Club
International Federation of Health Funds
International Foundation of Employee Benefit Plans
International Function Point Users Group
International Insurance Council
International Facility Management Association

JLM Associates
Japan Virginia Society

Kiwanis Club of Washington

Law Society of New South Wales
Life Insurance Marketing and Research Association

Mary Welch & Associates
Maryland Association of HMO's
Maryland Chamber of Commerce
Maryland Health Care Coalition
Maryland Hospital Education Institute
Maryland State Bar Association
Maryland Association for Home Care Inc.
Medical Administrator's Conference
Medical Advisory Council
Medical Group Management Association
Medical Society of D.C.
Medical Society of VA
Metropolitan Washington Public Health Association
Mid-Atlantic Cash Management Association
Mid-Atlantic Micro-Focus User Group, Ltd.
Middle Atlantic Actuarial Club

Montgomery County Chamber of Commerce
Montgomery County Medical Society
Maryland State Association of Quality Assurance Professionals

New South Wales Council on the Aging
New South Wales Medical Board
New South Wales Medical Defense Union
National Alliances of Business
National Association for Female Executives
National Association for Foreign Student Affairs
National Association for Healthcare Quality
National Association for Home Care
National Association of Certified Fraud Examiners
National Association of Desktop Publishers
National Association of Health Data Organizations
National Association of Health Underwriters
National Association of Life Underwriters
National Association of Prime Users
National Association of Social Workers
National Capital Area Healthcare Coalition
National Capital Chapter of the Public Relations Society of America
National Council on Aging
National Flight Nurses Association
National Health Care Anti-Fraud Association
National Health Lawyer Association
National Institute of Accountants
National Other Party Liability Group
National Rolm Users
National Society for Performance & Instruction
National Systems Programmers Association
National Wellness Institute, Inc.
National Women's Health Resource Center
National Association of Credit Managers
National Nurses Substance Disorder Organization
Northern Virginia Life Underwriters Association
Northwest Airlines World Perks

Organizational Development Network

Pan American Airlines Clipper Club
Pan American World Airways
Pine Tree Club
PR Newswire
Price Club
Prince George's Chamber of Commerce
Professional Insurance Marketing Association
Public Relations Society of America
Purchasing Management Association

Register of Medical Practitioners
Richmond Chamber of Commerce
Richmond Human Resource Management Association
Risk & Insurance Management Society, Inc.
Rotary Club of St. Thomas

Rotary International

Saint James Club
Sam's Wholesale Club
Self-Insurance Institute of America
Seven Eastern Regional Group
Society for Human Resource Management
Society of Actuaries
Society of Competitor Intelligence Professionals
Society of General Internal Medicine
Society of Professionals in Dispute Resolution
Society of Teachers of Family Medicin
Society of Professional Benefits Administrators
Sporting Club
Springfield Chamber of Commerce

Telecommunications Managers Association of the Capital Area
The Advertising Club of Metropolitan Washington
TWA Ambassadors Club
The Association of American Geographers
The Chartered Institute of Marketing
The Computer Measurement Group Inc.
The Economic Club of Washington
The European Institute
The Forum for Health Care Planning
The Greater Washington Board of Trade
The Hastings Center
The International Society for Planning & Strategic Management
The Law Society of NSW
The Medical Board of QLD
Toastmasters International
Tournament Players Club of Avenel
Tower Club
Treasury Management Association

United Airlines Red Carpet Club
U.S.Air Club
U.S. Chamber of Commerce

Virginia Association of HMO's
Virginia Association of Life Underwriters
Virginia Health Care Association
Virginia Nurses Association
Virginia Society of Certified Public Accountants
Virginia State Bar

Washington Board of Trade
Washington Personnel Association
Washington Women in Public Relations
Washington Metropolitan Postal Customers Council
Washington Area Computer Assisted Systems Engineering
Wellness Council of the National Capital Area
Willow Creek Country Club
University of Wisconsin Alumni Association
Women in Employee Benefits
World Medical Association

Xplor International Electronic Printing Association

CITY CLUB
OF WASHINGTON

November 24, 1992

Mr. John F. Forbes
United States Senate
100 Russell Building
Washington, DC 20510

Dear Mr. Forbes:

Enclosed is the requested information per your subpoena of November 10th, 1992. The following is a brief summary of the Memberships that are or were established at the City Club of Washington:

Member	Date joined	Date resigned	Deposit Paid	TAM Mbr
V. Brian	Aug 1986	Jul 1989	$1,440	No
G. Brown	Dec 1988		$2,000	Yes
H. Cain	Mar 1992		$1,750	No
G. Ecker	Feb 1992		-0-	Yes
J. Gamble	Aug 1986	Nov 1992	$1,440	No
B. Giuliani	Aug 1986		$1,440	Yes
R. Groppe	Feb 1988		$2,000	Yes
W. Hendren	Mar 1992	Oct 1992	-0-	No
J. Kahl	Sept 1989		-0-	Yes
D. Kestel	Aug 1986	Nov 1992	$1,440	No
P. Kongstvedt	Sep 1991		$ 975	Yes
B. Larsen-Becker	Mar 1991		$ 250	No
M. Lehnhard	Apr 1989		$2.000	No
M. Long	Sep 1989		-0-	Yes
G. Morris	Jan 1992		$1,750	Yes
S. Pace	Jul 1989		$ 250	Yes
W. Poffenberger	Sep 1989		$ 250	Yes
S. Ricchetti	Apr 1987	May 1991	$2,000	No
H. Riley, Jr.	Jul 1987	Nov 1992	$1,680	No
E. Shields	Jun 1987	Dec 1988	$1,680	No
A. Spielman	Mar 1992		$1,750	No
B. Tresnowski	Nov 1991		$ 975	No
J. Waller	Mar 1991		$ 550	No

*All deposits are refunded to the owner(i.e. the company), 30 years from the date of joining.

**TAM is a prepayment of dues, through January, 1995.

Please let give me a call if we can be of further assistance or if you need any clarification.

Sincerely,

John Nicholas
Club Manager

enclosure

Columbia Square, Concourse Level, 555 13th Street, N.W.
Washington, D.C. 20004 202/347-0818

A F F I D A V I T

OF

SUSAN HOLLRITH

Senate Permanent Subcommittee on Investigations

EXHIBIT # 88

Mr. Chairman and Members of the Subcommittee, my name is Susan Hollrith, and I was employed by National Capital Administrative Services, Inc. (NCAS), a wholly owned subsidiary of Blue Cross and Blue Shield of the National Capital Area (BCBSNCA) from October 8th, 1990, until February 28th, 1992. I was the Director of Finance and Administration and was responsible for the finance, accounting, personnel, and medical claims audit functions.

During my tenure at NCAS, I became intimately familiar with its financial operations and discovered numerous practices that I felt ranged from those that appeared to be blatantly illegal to those that simply showed a flagrant disregard for sound business practice. I brought these problems to the attention of my supervisor, Joseph Crowley, the Vice President of Operations, as well as to his boss, William Hendren, the President of NCAS. It rapidly became apparent that they had no intention of correcting any of these questionable practices. Typifying this attitude was their frequently stated belief (when confronted with a questionable or seemingly illegal practice) that they would never be caught. It also became apparent that further inquiries of this sort would cost me my job.

I subsequently raised these same issues with a Group Hospitalization and Medical Services, Inc. (GHMSI), Internal Auditor, Lorna Saladino, and the head of GHMSI Internal Audit, Jimmy Riggs, who felt the issues were serious enough to merit the immediate attention of Joseph Gamble, GHMSI Chairman of the Board. Their response was to immediately place me on a leave of absence, mount an investigation that consisted primarily of searching for my personnel file, and ultimately, to "white wash" the whole incident. Their actions led me to believe they did not have the interests of the company or its clients at heart, but held their own self-interests paramount and additionally, that while they knew certain practices were going on, and knew those same practices were questionable, at best, they did not care. I welcome the opportunity to present this information to the Subcommittee and hope it can be used to highlight the prevailing attitude of senior management at NCAS and the serious problems it has caused.

The most serious problem I encountered at NCAS involved the submission of two claims, which I believed to be fraudulent, on a contract NCAS held with the Agency for International Development (AID). It might be useful, however, to first provide a brief summation of the type of work NCAS performs for its clients. NCAS is a Third Party Administrator (TPA), which

SH

is a hybrid between a full-service health insurance company and a situation where an employer pays its own health insurance claims. TPA's fall into a murky, largely unregulated area of the law. Roughly one-third of all Americans are covered by companies that self-insure their health plans. Generally speaking, these employers will hire a TPA to assist with the set-up, design, administration, and claims-paying activities associated with their health plans. All funding for the claims expense is paid by the employer, and the TPA assumes no insurance risk, merely acting in a fiduciary capacity.

NCAS contracts independently with both large and small clients and also acts as a subcontractor to Blue Cross and Blue Shield of the National Capital Area (BCBSNCA) to perform claims processing on some large Federal groups, such as the Federal Deposit Insurance Corporation. Since its inception, NCAS has used a claims processing system and software owned by Insurdata, Inc., which is headquartered in Texas. NCAS is totally dependent on this system, leased from Insurdata. NCAS initially bought the licensing and marketing rights to this system for the mid-Atlantic region and later expanded its rights to market and sublicense to any Blue Cross/Blue Shield organization or affiliate in the U.S. NCAS currently owns just over 18% of the issued and outstanding shares of Insurdata stock. NCAS's two major lines of business are the "network," which is the sublicensing of the Insurdata system, and the TPA business.

NCAS acted as a TPA on the contract (DHR-0000-C-00-8001-00) with AID. Under this contract, NCAS processed and paid claims for an AID plan called the Health and Accident Coverage (HAC) Program. The contract period of performance was from January 1, 1988, through December 31, 1990, with two additional one-year options, for a total possible period of performance of five years. The contract was a firm, fixed price one, with AID paying NCAS monthly fees of $1.44 per insured in 1988, $1.60 in 1989, and $1.71 in 1990, with further increases in subsequent years. There was also a $5.00 fee charged to AID for each new plan participant. To pay the AID health claims and to remit NCAS's processing fees, AID issued a letter of credit in favor of NCAS. Funds were then wired into NCAS's account as needed, usually at two- to three-week intervals. NCAS was entrusted with the responsibility to use these funds for two purposes -- to pay AID health claims and to pay themselves for services performed under the contract. A complete accounting and certification was required of NCAS each time AID had to wire additional funds into the account. The interest earned on this account, according to applicable Treasury Regulations, belonged to AID.

After my arrival at NCAS in October of 1990, I became aware that NCAS had submitted two claims to AID requesting additional compensation beyond that which was stipulated in the fixed price contract. The basis for these two claims, which covered five years and requested roughly $1,200,000 in

PCH

additional fees, was that while AID had stated in the original request for proposal (RFP) that the enrollment data would be transmitted electronically, in actuality, the electronic tape transfer never worked and all data was manually supplied. An additional basis for the claim was that much of the data supplied by the Government was erroneous -- i.e., the data was defective. NCAS justified this added expense by providing AID with a document that purportedly detailed the extra labor and other costs ostensibly caused by the faulty electronic tape system and enrollment data.

I went back to the original RFP to research the NCAS bases for its claim and found that it did not say categorically that the data would be transferred electronically, but that it would be transferred electronically or manually -- by whatever means could be made to work. Another fact, which seemed obvious, was that NCAS would have lost money on this contract, even if the enrollment tape had worked perfectly. In my opinion, NCAS simply bid the contract too low. The increase NCAS requested in their 1988 claim to AID was more than double the amount they were entitled to contractually, and there was no way all of this loss was due to the electronic tape issue. These facts notwithstanding, AID contracting officer, Ed Thomas, authorized payment of NCAS's 1988 claim for $321,553 in March, 1990.

Also in March 1990, NCAS submitted another claim for payment over and above the contractual amount for 1989 through 1992. This claim used the same methodology and format as the 1988 claim. Since it was 1990, and the actual number of plan participants during 1989 was known, NCAS calculated the additional revenue that the requested rate increase would yield at $194,772 for 1989. The rate increase above the contractual amount for 1990 was $228,043. These claims were prepared at the direction of Hendren and Crowley.

Although AID had already paid the 1988 claim, and Ed Thomas had assured NCAS that the 1989 claim would be paid during the new fiscal year, in the interim he retired and a new contracting officer, Gary Kinney, assumed his position. Gary Kinney requested that an audit by Martin E. Segal (a consulting firm) be conducted before he agreed to pay the 1989 claim. Meanwhile, 1990 passed with no resolution on the 1989 or 1990 claims and word came back that the Martin E. Segal audit was inconclusive.

In January, 1991, after much pressure from NCAS, AID authorized the payment of a higher provisional rate for 1991. This rate increase, raising the monthly fee to $4.14 -- more than double the contractual rate -- was the exact amount NCAS had requested in the second claim. The higher rate was conditional, in that it was tied to the 1989 claim. If the claim were denied, the money would have to be paid back to AID. In 1991, Gary Kinney requested a DCAA (Defense Contract Audit

Agency) audit of the 1989 claim, since the Martin E. Segal audit had not rendered conclusive results.

Upon reviewing the data and documentation used to prepare the 1989 claim with Teri Feider, the Supervisor of Accounting, we found that none of the source documents, such as timesheets, labor runs, etc., tied out to the claim. I could not figure out how the claim had been generated. In an attempt to piece together the puzzle, I turned to the 1988 claim for clues and found that there were virtually no source documents to support it either. There was nothing but a single sheet of paper with some cryptic notes on it. It appeared, in short, that no effort had been made to determine what the actual costs were.

According to the cover letter for the 1988 claim, which was certified by NCAS President, Bill Hendren, that claim was purportedly based on months of time studies. Yet, I could find no evidence to support this. The cover letter for the 1989 claim, also certified by Hendren, said that it was based on a four-month time study, yet I could only find 15 days of time sheets for 1989. Furthermore, the 1989 timesheets were segregated into two stacks; those that showed AID time that had been separated out, and those that did not. For example, if an employee had worked on AID for two hours on Monday, but not at all on Tuesday, the timesheet for Monday was in one pile with the claim, and the Tuesday timesheet was stashed under a desk.

After I collated the timesheets by employee in chronological order, the whole picture became clearer. If during the three-week sample period, an employee had worked a total of 10 hours on AID over a two-day period, then that ratio -- 10/2, or five hours per day -- was used to extrapolate the AID time worked for the year. However, this was an incorrect calculation -- the correct one would have been 10/15, since the sampling period contained 15 days. This would have resulted in less than one hour per day, as opposed to the five hours NCAS charged in the claim.

This methodology was even worse with part-time employees, some of whom were in the claim for far more hours than a full-time person and/or more hours than they had ever worked at NCAS. Certain employees had two and three timesheets for the same day, some with AID time, and others without any AID time. Also, several employees who had multiple timesheets for the same day seemed to forget how to spell their names from one timesheet to the next. Other employees were priced out at their supervisor's much higher labor rate.

A computer diskette labeled "AID" in the stack I had inherited from my predecessor completed the puzzle. It had quite a few files on it dating back to the time when the claims were prepared. On the diskette NCAS had started with the amount of money they felt they needed for the AID contract to be

PCH

profitable and worked backwards to determine how many labor hours they needed to claim for each person. Overall, it appeared NCAS had falsified employee and created work hours that had never been performed.

On June 6, 1991, Bill Hendren stopped by the accounting area to see how our review of the AID claim was going. I was in Accounting Supervisor, Teri Feider's office, discussing other issues with her. I told him in detail about the numbers being worked backwards, the phony extrapolation techniques, the missing and altered timesheets, and the bad labor rates. I reminded him that he had signed the claims' certification statements and warned him that I thought this was fraud, and he could go to jail. I advised him to withdraw the claims and inform AID.

Hendren became furious with me and told me that he "... wasn't going to jail," and that "... we wouldn't tell the Government about these things...That we'd just let them do the audit and see what they came up with ... that we don't want more than we're due and that we could work things out with the DCAA." In retrospect, the fact that Hendren never questioned my findings, or wanted more details -- as if he were hearing such astounding news for the first time -- was very telling, and should have alerted me more about the implications of what I had seen and heard; but at the time, I was too startled to notice.

After I made two other futile attempts to tell Hendren how dubious the claim was and that we should withdraw it, the DCAA auditor, Mike Grivnovics, arrived at NCAS. At this point, I found myself between the proverbial rock and a hard place. Knowing as I did about the claims, I felt an obligation to inform the auditor. However, if I did, I knew that ultimately, it would cost me my job. Still, when faced with the choice between unemployment and going along with something I knew was wrong, unemployment won hands down. Accordingly, on June 10, 1991, I told Grivnovics the whole story, what documents to ask for, and made him swear that he would say he found out about this on his own.

On June 28, 1991, at the DCAA exit conference with Hendren and myself, Grivnovics told Hendren about all of the same issues I had covered with him on June 6th. Hendren acted surprised. Immediately after the exit conference, Hendren and I went to his office where he called NCAS Vice President, Joe Crowley, on the speakerphone. Joe had been in the Persian Gulf, but was back in the U.S. After Hendren detailed Grivnovics's charges, Joe said, "How could he find out about that? ... I mean, how would he find that? ... well, I wasn't involved with the numbers. It was... Vanessa, and Suzanne ... and Ross ... they did the numbers. I wasn't involved." (Vanessa Kenney, Suzanne Keane, and Ross Welti were former NCAS employees, two of whom worked for Crowley.) These remarks, plus all the notes in

the AID claim files that appeared to be in Joe Crowley's handwriting, convinced me that he knew about the apparent fraud.

On October 14, 1991, after I left NCAS, I telephoned one of my predecessors, the former Director of Finance, Vanessa Kenney, and asked her what had happened with the AID claims. She told me that she and the General Manager, Suzanne Keane, had come up with a list of contracts that were unprofitable for NCAS, and AID was at the top of that list. They estimated that NCAS was losing $321,000 a year on the AID contract.

AID had been Joe Crowley's "baby," since he had headed up the proposal activity and won the contract for NCAS. As the red ink continued to flow at NCAS and it became apparent that the AID contract was not profitable, Crowley was generally held responsible for the mounting losses. According to those who worked at NCAS at the time, Crowley and Suzanne Keane were enemies who used to hold shouting matches out in the hall. When Suzanne Keane found out that the AID contract was the number-one money loser, she used this information at a Monday morning status meeting to make Crowley look bad. She really rubbed his face in it.

Crowley responded by enlisting the services of Hogan & Hartson, a law firm, to find out how he could recoup the losses on the AID contract and save face. Hogan & Hartson instructed him on how to file a claim for equitable adjustment. The amount of the 1988 claim, as detailed before, was $321,553, an amount incredibly close to the figure NCAS calculated it was losing on the contract. Crowley had a powerful motive for wanting to collect this money by any means possible, since NCAS was unprofitable and the AID contract, his "baby," was driving it deeper into the hole.

According to Vanessa Kenney, the initial claim she prepared was fairly well documented and the numbers tied out to the source documents. However, Hendren and Crowley did not like the numbers, and someone else reworked the claim. Vanessa told me she refused to sign any documents pertaining to the AID claim or to be present if auditors came in. She also stated that on two occasions she had advised Tom McGovern, a lawyer at Hogan & Hartson, that she was uneasy about the numbers in the claim.

On August 30, 1991, I sat with Bill Hendren in my office and went over the list of apparent illegalities one more time. However, I was concerned about more than just the AID claim. NCAS had never been profitable, and a natural consequence of this was that there was a problem with cash flow. NCAS's solution to this problem, in apparent violation of existing legal requirements, was to commingle their clients' money with their own by electronically cleaning out the clients' claim accounts at the bank each night. This is known as "cash sweeping."

SH

In the case of AID, this meant that each night, any deposits made by AID would be swept into NCAS's operating account. Moreover, as a result, the AID account always had essentially a zero closing balance, and thus no interest could ever accrue on the funds that should have been maintained there until claims were actually paid. I estimate that AID lost approximately $30,000 worth of interest as a result of NCAS's cash sweeping policy.

Beyond AID, NCAS did the same thing with other clients' claims accounts. In effect, the money NCAS's clients thought was being used to pay their employees' health claims was being used by NCAS for its own purposes. Thus, for example, as of the end of 1990, NCAS had spent $1.8 million dollars of these clients' claim account funds on NCAS operating expenses, such as rent, telephones, and Insurdata payments. This latter sum is based on my determination that NCAS's operating account had a $1.8 million dollar overdraft as of year end 1990.

In the August 30th meeting with Hendren, therefore, I specifically brought up the issues of unlawfully commingling clients' cash with our own, failing to remit the interest earned on clients' money to the clients, and spending $1.8 million dollars of our clients' funds for our own purposes. I said that I had researched this by, for example, talking about it with a Department of Labor official, Betty Briggs. I also said that a co-worker had called the Society for Professional Benefit Administrators (SPBA), which represents the TPA industry. Both of these sources strongly advised against the practice of sweeping plan assets into our own account. Indeed, Betty Briggs confirmed the illegality of this practice, informing me that it was a violation of our fiduciary responsibility and the Employee Retirement and Income Security Act (ERISA). Mr. Hendren said he would check these issues out at Blue Cross the next time he went downtown. He came back to me a day or two later and reported that he had discussed them with either Wright Poffenberger, BCBSNCA Treasurer, or Bill Krumenacker, BCBSNCA Controller (I don't recall which one), who had told him that it was a standard company practice to cash sweep.

On September 23, 1991, Lorna Saladino, a BCBSNCA Internal Auditor, called me and asked for some additional information on an audit issue, which I agreed to research and get to her. She also asked about the situation at NCAS, and I leveled with her, telling her about the serious problems with the AID claims, the commingling of clients' money with our own, the failure to remit interest to clients, the $1.8 million misuse of client account funds, and the "misdirection" of $2,783.79 in corporate funds by my boss, Joseph Crowley. She told me she wanted to take this information to her boss, Jimmy Riggs, the head of Internal Audit for BCBSNCA. On September 24th, Lorna called back and said she had gone to Jimmy Riggs and that he, in turn, was going to take these issues to Joseph Gamble, the GHMSI Board Chairman. On Friday, September 27th,

SH

Hendren and Crowley went downtown to BCBSNCA for a meeting with Mr. Gamble. I don't know what the meeting was about, but I believe the audit issues were raised because late that same afternoon, Crowley stormed into my office, told me not to report to work on Monday, and threatened me physically if I did.

By the time the Internal Auditors from BCBSNCA arrived at NCAS to investigate the issues I had raised, I had already been forced out of NCAS, i.e., I had been placed on extended leave (which, at first, was paid, but later was unpaid). While on leave, I spoke with Jimmy Riggs on the phone and he indicated that he and Lorna wanted to meet with me. I asked what they would do with the audit results and he told me that they would be given directly to Mr. Gamble and would not be shared with anyone else. I met with Riggs and Saladino on October 8, 1991 and went over all the issues. To date, I have never seen the audit report or learned of its results. Despite a subpoena, NCAS refused to provide the audit report to the AID Inspector General or the Department of Justice.

In an October 16, 1991 meeting, while still out on leave, I tried once again to address the issue of the AID claim with Hendren and Crowley. Both of them insisted that the internal audit would address the problems associated with the claim and that they would follow the audit, as well as any related, recommendations from the GHMSI board. At this time, I also asked Hendren about the phone call we had received from Paul Knepp of AID in the fall of 1990, in which Knepp had specifically asked where the interest on AID's claim account funds was. Hendren, in turn, asked me if the contract with AID addressed this issue. I told him that the contract did not, but that the issue was specifically addressed in a Government handbook we had received when we were awarded the contract. I also reminded him that he, Dave Schmidtknecht (an NCAS accountant), and I had calculated the amount of interest potentially owed to AID in response to Paul Knepp's phone call.

Hendren's response to this reference to the unremitted AID interest was, "I am not going to be proactive and go to AID and say, by the way, send me a letter so I can tell you how much interest I owe you. I mean, I think it is <u>their</u> responsibility, rather than just a phone call, to put some of these things in writing to us, about what they want to do ... and I'm sure there are thousands of regulations in the Federal Government that we are not aware of -- We couldn't afford to <u>become</u> aware of them. We would have to charge them twice or three times as much as we do." I then asked Hendren if, since we <u>were</u> aware that we owed AID the money and we <u>did</u> know about it, didn't he think we should give them the money back. Both Hendren and Crowley disagreed, with the former saying, "I don't at all! I think they have to come and ask me for it." This exchange typifies the attitude Hendren and Crowley had about their dealings with the Government.

1EH

Another way NCAS used to alleviate the critical cash flow problems it experienced, was through the line of credit and loan (LOC) GHMSI had set up for the company. This debt increased astronomically over the years, growing from $1 million dollars at NCAS's inception to $5.6 million dollars today. These figures do not include the unpaid interest on the debt, which has continued to accrue. As of the time I left the company, to the best of my knowledge, NCAS has never made any principal or interest payments on this loan, despite warnings from their external auditor, Price Waterhouse, that they would be reclassified as non-performing assets on GHMSI's books if NCAS did not do so.

It is important to note that as of the end of 1991, according to filings with the D.C. Insurance Commissioner, GHMSI had over $120 million dollars of this type of dubious inter-company debt on its books, classified as "miscellaneous account receivables." On these same forms, moreover, GHMSI cited a reserve figure of just over $100 million, which included this $120 million in miscellaneous account receivables. However, and of glaring potential significance, without the latter's inclusion, GHMSI's reserve figure would be negative.

GHMSI also infused cash into NCAS by subcontracting with it. For example, on the FDIC contract, which BCBSNCA won as the prime contractor, NCAS processed the claims as a subcontractor. BCBSNCA paid NCAS for these services in cash, by wiring the money into NCAS's bank account. No attempt was ever made by BCBSNCA to deduct any of NCAS's grossly overdue loan repayments from these remittances. Along the same lines, when GHMSI or BSBCNCA performed services for NCAS, NCAS never paid in cash. Instead, repayment was accomplished via a book accounting entry, which only added to NCAS's mounting losses.

The losses NCAS was incurring and the severe cash flow problem resulted in other questionable accounting practices. For instance, of the AID claims submitted, only one was ever paid and now even it must be paid back. Yet, all of these claims were booked as valid sales and current accounts receivable in an effort to camouflage NCAS's unprofitable bottom line. In 1990 alone, these claims amounted to over $400,000. As of the third quarter of 1992, this revenue was still on the company's books and had never been reversed, even though, by then, the Department of Justice had accused NCAS of attempting to defraud AID.

Another area where the numbers were manipulated was on the expense side of the income statement. For example, when the company was relatively young and not under pressure to make a profit, the Insurdata computer ports were immediately expensed. Later on, when I worked there, NCAS depreciated these same assets over several different and longer periods of time in order to lower the expenses and improve the bottom line. This resulted in totally inconsistent depreciation schedules for the

SEH

same asset and allowed NCAS to manipulate the expense base to make it appear more profitable.

There are too many other examples of poor accounting practices to detail here but, generally speaking, GAAP (Generally Accepted Accounting Practices) was not the rule. I expressed my concern about some of these practices to Hendren, but he was unconcerned. Indeed, I had a hard time getting Hendren to focus on the financial status of the company, even when he knew he was going into financial review meetings with Mr. Gamble. I finally resorted to writing crib notes on his copy of the financials, so he could talk semi-intelligently on those occasions. Hendren would just go into the meetings and wing it, not even taking the time to review the numbers beforehand. In the meetings I attended, I was also struck by the fact that Mr. Gamble did not grill Hendren on the losses. Hendren also got off lightly in this regard when the topic of NCAS losses came up at quarterly financial meetings attended by GHMSI management and representatives of all GHMSI subsidiaries.

As a TPA, NCAS was prohibited by law from collecting commissions or fees from insurance and reinsurance companies that it recommended to its clients. NCAS was supposed to be acting in a fiduciary capacity and in the best interests of its clients, not itself. To get around this rule, NCAS set up a wholly-owned subsidiary called NCAS Insurance Agency (NCAS/IA) to collect the commissions and fees it could not legally collect. NCAS/IA also engaged in other lines of business, such as hospital discounts. An NCAS employee would target an NCAS client with an insured employee who had racked up a major hospital bill. The NCAS employee would then contact the hospital on behalf of the client and negotiate a discount on the bill, in return for prompt payment. NCAS kept part of the discount as payment for its services, and this revenue was booked to NCAS/IA.

Since NCAS/IA was a legal entity only, with no building and few employees, it had virtually no expenses. This could have made it very profitable. However, prior to my arrival at NCAS, the "97% rule" was used to allocate costs to NCAS/IA, by shifting expenses off NCAS's books onto NCAS/IA's. Each month NCAS charged NCAS/IA an amount equal to exactly 97% of NCAS/IA's revenue, as fees for the use of NCAS employees and facilities. This technique was so well known that even Mr. Gamble mentioned it at a financial review meeting I attended. When I discovered this practice, I told Hendren we couldn't use it because there was no basis for it, and that we needed to have an allocation technique that would pass an audit. His response, which is also indicative of the attitude I saw in his management style, was, "who's going to catch me?"

Another area that illustrates the questionable practices and blatant self-dealing I observed on the part of senior NCAS managers involved the sale of the NCAS Mid-West (NCAS-MW) branch

office in Michigan. NCAS-MW was originally purchased from Blue Cross of Michigan. While it was still under Blue Cross of Michigan's ownership it was called Blue Ribbon. A condition of the sale to NCAS was that Blue Cross of Michigan took back a note from NCAS, which was secured by a lien on the physical assets of the operation. An additional stipulation was that NCAS-MW could not be sold without the written permission of Blue Cross of Michigan. NCAS and NCAS-MW were one entity until August 1, 1991, i.e., the latter was simply a separate geographic location from the former. NCAS-MW was not a subsidiary and did not have a separate Federal tax ID number. It was run as a separate profit center, and NCAS management attempted to monitor its profitability (or lack thereof) by keeping an internal set of books on its operations.

On July 31, 1991, NCAS sold NCAS-MW to Joe Crowley (30% interest) and two former NCAS-MW employees, Chuck Baker (30% interest) and E. Lee Hubbard (30% interest). NCAS retained a 10% interest to circumvent an agreement NCAS had with Insurdata, which owned the claims-processing system. Per the agreement, the Insurdata system was only supposed to be licensed for use by Blue Cross and Blue Shield or their affiliates. If NCAS had not retained a 10% share, NCAS-MW would not have qualified as an affiliate. Even so, Insurdata was not informed of the sale. After the sale, the three partners, Crowley, Baker, and Hubbard, established a corporation called Modern Benefits Management, Inc. It conducts business under the trade name of NCAS-MW, a practice that is consistent with other licensees in the Insurdata system.

Just prior to the sale of NCAS-MW, two interesting things occurred. On July 19, 1991, the NCAS-MW claim accounts were put on a cash sweep basis at the National Bank of Detroit (NBD) by Joe Crowley, without his partners' (Baker and Hubbard) consent or knowledge. I was not aware of this until I got a panicked call from Baker asking if I had wired money out of the United Auto Workers (UAW) claim account using a reverse ACH. (A reverse ACH is a verbal code authorizing the transfer of funds out of one account, into another.) I told Baker that I had not done so, as I knew this would be illegal. Baker remained doubtful and then told me that the bank statement said "ZBA." I told him this meant zero balance account, and that the reason there was no money in the UAW claim account was that it was all sitting in the NCAS-MW operating account. He asked me if I had set up the cash sweep, and I again denied it, saying that everyone knew how illegal it would be to do that, especially in Michigan where this is also a violation of State law. I had Baker FAX me the bank records to confirm the cash sweep. Both Baker and I suspected that Joe Crowley had set it up, so I went to his office and told him someone had set up the NCAS-MW claim accounts at NBD on a cash sweep basis starting July 19th. He became upset and said he had specifically told the NBD bank people not to begin the sweep until after the date of the sale (July 31st). I relayed this information to Baker and Hubbard,

who were furious and proceeded to cancel the cash sweep without Crowley's knowledge.

The second incident took place just prior to finalizing the sale of NCAS-MW. Chuck Baker and Lee Hubbard flew in from Michigan for a meeting on the sale. I was also present at this meeting, where it became apparent that Hendren had agreed to let the new corporation, Modern Benefits, continue to do business under NCAS's Federal tax ID number, because the partners did not want to spend the money to hire an attorney and formally incorporate -- which they felt would be necessary to get such a number. I questioned this action and after being overruled, called Warrenetta Baker, in the BCBSNCA tax department, who confirmed this was not supposed to be done. I relayed this to Hendren, who finally concurred. The point, however, is that if I had not bothered to check, they would have proceeded without having established the legality of their actions in this regard.

In addition, per their contract with Blue Cross of Michigan, NCAS was not allowed to sell NCAS-MW without the written permission of Blue Cross of Michigan and the latter still held a lien on the physical assets of NCAS-MW. This lien served as collateral on the loan Blue Cross of Michigan had made to NCAS -- a loan that was still outstanding. NCAS violated both of these provisions when it allowed Joe Crowley, Chuck Baker, and Lee Hubbard to buy the operation on July 31, 1991. Prior to the sale, NCAS had other outside parties who expressed interest in buying the operation and none of these possible deals involved NCAS financing. However, these offers were turned down in favor of selling the business to Crowley and his partners. Crowley personally wrote up the contract to sell the business to himself and took much of the boilerplate in the document from the original Blue Ribbon purchase contract. Because of this, he was well aware of the restrictions on the resale of the business and was also aware that in selling it NCAS was violating those same restrictions. Crowley and I had a discussion on these last two points, as well.

I was also aware of many errors and inconsistencies in the contract Crowley wrote up to purchase NCAS-MW, and had marked up a copy with the help of my staff. I gave the marked-up copy to Crowley prior to the sale being finalized. A month later, in a conversation with Bill Hendren, I learned that Crowley had never corrected any of these errors, nor had he passed this information along to Hendren -- it presumably being in his best interests not to do so. Hendren appeared angry that Crowley had not told him about these problems. I gave Hendren a copy of the marked-up contract and informed him that, per a phone call I had received from Chuck Baker, the partners intended to default on the agreement and had retained legal counsel. According to Baker, their counsel claimed that the contract contained so many errors that it was virtually unenforceable.

Yet another problem with this transaction was that it involved a series of debt instruments totalling $251,310.47. These notes, which enabled Crowley, Baker, and Hubbard to purchase NCAS-MW, were accepted in lieu of cash by NCAS. Essentially, this was a loan from NCAS to the partners for the purchase of NCAS-MW. This loan appears to be in violation of Virginia Code 38.2-210, which specifies that such loans are prohibited. According to the Code, except as provided in 38.2-212, no insurer, legal services plan, health services plan, dental or optometric services plan, health maintenance organization, or home protection company, transacting business in Virginia shall make a loan, either directly or indirectly, to any of its officers or directors. In addition, the Code stipulates that no such company shall make a loan to any other corporation or business unit in which any of its officers or directors has a substantial interest, nor shall such officer or director accept or receive any such loan directly or indirectly. According to NCAS's audited financial statement covering 1990 and 1991, the President of NCAS-MW, Joe Crowley, was also an officer of NCAS, and thus this transaction appears to have violated the law, as well as being a flagrant case of self-dealing.

Another small, but pointed example of mismanagement at NCAS can be seen in a decision Hendren made involving business with another GHMSI company, EMTRUST. Specifically EMTRUST objected to, the number of insured covered in a contract NCAS was administering on behalf of EMTRUST. In response to this objection, in a conversation Hendren had with me and another NCAS employee, Linda Geisinger, he arbitrarily chose the year of his birth (1937) as the number of insured. This number had no basis in fact and was lower than what the number should have been.

In conclusion, I feel that NCAS has been poorly managed for years and that Hendren, Crowley, and others in senior management have continuously involved themselves in business practices of a very questionable and, at times, illegal nature. One of my co-workers said, "If Hendren and Crowley spent as much time managing the business as they did on their illegal schemes, NCAS would be a profitable company." I tend to agree with this statement. The fact that NCAS executives have never taken a pay cut, while slicing the pay of lower level employees 25%-30% on Labor Day, 1991, speaks for itself. In 1992, again around Labor Day, they cut the compensation of lower level employees even further. NCAS management's response to any business crisis was to convene a meeting or conference at an exclusive, off-site location -- when the going got tough, they went to the Tower Club.

Instead of building the business, Bill Hendren concerned himself with buying Christmas calendars using art and photographs taken by his wife. Instead of making the business profitable, Joe Crowley concerned himself with funneling NCAS

travel business to a travel agency where his wife was employed. Instead of providing superior health insurance service to its customers, they concerned themselves with self-dealing in the form of loaning corporate funds to each other to buy a business that they were not at liberty to sell. Over and over again, while a near-crisis has existed in this country for years regarding the cost and soundness of health care insurance, the management of this company focused their energies on themselves. Because of these actions, I was embarrassed to be a manager at NCAS. It is because of these actions that I offer this sworn statement for the record today.

I have read, reviewed, and initialed each page of this statement consisting of 16 pages, and I affirm, to the best of my knowledge, belief, and recollection, that the statements contained herein are true and correct.

Susan Hollrith

Sworn to and subscribed before me
this 22ndday of January, 1993.

Notary Public

My commission expires:

7-31-96

Senate Permanent Subcommittee on Investigations
EXHIBIT # 89.

A F F I D A V I T
OF
TERI FEIDER

My name is Teri Feider and I was employed by National Capital Administrative Services, Incorporated, or NCAS as it is commonly known, from November, 1988 until November, 1991. NCAS is a wholly owned subsidiary of Group Hospitalization and Medical Services, Incorporated (GHMSI) and is a third party administrator (TPA), providing administrative support to self-insured employee health benefit programs. They are also involved in licensing the use of the Insurdata claims processing system to other TPAs. I started at NCAS as a staff accountant and was hired to handle the increased volume of business brought on as a result of the purchase of a TPA in Michigan. This TPA became a branch office known as NCAS Mid-West. I was promoted to Senior Accountant in the late summer or early fall of ~~1990~~ 1989 and subsequently became the Accounting Supervisor in March, ~~1991.~~ I decided to work part time in August 1991 for personal reasons and left the company in November 1991.

Having worked in the accounting department, I am familiar with the preparation of budgets, billing procedures, accounts payable and receivable, monthly financial statements, reconciliations, and payroll as they pertain to NCAS. I am also familiar with NCAS's cash flow situation, and was there during the initial stages of the sale of its Mid-West branch office. I also performed accounting services for NCAS Insurance Agency, a wholly owned subsidiary of NCAS.

I assisted in the preparation of yearly forecasts for NCAS, but I felt these were never very accurate. The outcome of the forecast was driven by numerous formulas based on plugged in numbers, such as administration fee rates or an expected number of new groups to be enrolled. The program used to prepare the forecast (Lotus Macros) would then assume the number of additional computer data lines, personnel, postage, etc. needed. It would also calculate estimated incomes by determining the estimated number of enrollees and average administration fees. The process for determining income from our licensing of the Insurdata system to other companies was basically the same, except it was slightly more accurate. These fees were more definable and we could more accurately forecast that only one or two new clients a year would be added.

The main reason the forecasts were so inaccurate was the assumptions made by the Lotus program. For example, it might calculate that for every 10,000 new enrollees added, a new claims processor would be needed and an additional $500 in postage fees would be created. However, these assumptions were never verified or studied. Another reason I found the forecasts to be inaccurate was that NCAS administration fees varied greatly depending on what type of coverage the group had chosen. Also, the larger the number of enrollees, the lower the

rate in most cases. As there was no way of estimating these factors with any degree of certainty, the numbers plugged into the forecast were arbitrary. To my knowledge, Dave Kreager (Vice President in charge of marketing) was never involved in the estimation of rates or expected enrollment even though he would have the most accurate information on these issues.

Typically these forecasts were prepared once a year for the long term (upcoming four years) and then approximately quarterly for the current year and the next. I usually assisted my boss in their preparation and in cases when Bill Hendren, the President of NCAS, needed revisions or additions, I would prepare them in my supervisor's absence. It was my understanding that Hendren was going to present the forecasts at meetings with GHMSI.

After the preparation, the forecasts were presented to Hendren for any revisions. Typically, if he did not like the bottom line figure, he would say: "That's too low; we have to change it." He'd then direct the accounting department to rework the forecast. He would make suggestions that would change the outcome of the formulas, such as increasing the administration rates or number of enrollees. Often, if he had suggested a bottom line figure he wanted to see, I would change items myself until the desired bottom line was reached. I would then inform him which items had been changed. Because the smallest change affected the outcomes greatly, it took only the slightest adjustments here and there to get the desired results. These adjustments might be based on assumptions made by Hendren concerning new clients and the number of new insureds NCAS would administer.

If we were working on a forecast for a quarterly update, we usually made the preceding months' figures accurate, but we were also told by Hendren to show a more positive trend as the year progressed. Even if a year began with a loss, and we knew that year was not going to be profitable, we always made sure that the trend for the next next year showed NCAS to be making a profit. Therefore as the actual figures for completed months replaced the forecast figures, it became more obvious the forecasts were not portraying accurate future performance.

As long as I worked there, NCAS never paid any money owed to GHMSI, while GHMSI paid it's accounts payable to NCAS in cash. NCAS did pay money to International Consulting Services (ICS), another GHMSI subsidiary, which was reinsuring several groups of clients NCAS had contracts with as a service to these clients. All of NCAS's accounts payable to GHMSI were recorded as book entries and never were paid. GHMSI, on the other hand, paid NCAS $100,000 to $120,000 per month for TPA services NCAS provided to clients of Blue Cross Blue Shield of the National Capital Area (BCBSNCA). This infusion of cash was one major source of funds used to keep NCAS solvent. If NCAS had to pay GHMSI what it owed for services it received from GHMSI, the

company would not have been able to continue to operate. At the time I worked there, NCAS also had a $3,000,000 note owed to GHMSI, which was used as the major source of operating funds for the company. NCAS had drawn all of the $3,000,000 and was not able to get any more money unless GHMSI increased the note. NCAS never made any principal or interest payments on this note while I was there. The interest expense alone was between $22,000 - $25,000 a month.

NCAS had several accounts with Sovran Bank that held client's claim funds. There were a few groups that did not share their accounts with other groups. These groups were the Agency for International Development (AID), Protocol, Herr Foods, Williams Industries, and Fairfax Hospital, as I recall. Most of the groups, however, were maintained in two large claims accounts known as the Sovran Miscellaneous and FDIC accounts. The FDIC account was originally used only for processing what were known as FDIC-OCC claims, but later groups were added and FDIC processing became known as NASCO. Sovran Miscellaneous began as the original claims account, but as more groups were added the FDIC account was used as well.

The determination for what account was to be used was generally decided by the manner in which the group intended to fund their claims. Some groups agreed to use ACH (automatic clearing house), which allowed NCAS to use verbal codes authorizing NCAS to transfer money from the client's bank to Sovran. These groups' funds were placed in the FDIC account. Only my boss, myself, and one other person in the office had access and authorization to use these codes. The ACH transactions benefitted NCAS because claims checks could be mailed directly from Insurdata without having to send them back to NCAS to await funding. All other groups, i.e., those that funded by wire or by check, were processed through the Sovran Miscellaneous account.

While these funds were for payment of clients' employee claims, NCAS "swept" them from these two accounts into one large operating account. This is a common practice in the TPA industry and is also known as a zero balance account. This was done on a daily basis and provided a float on which NCAS could operate. As claims needed to be paid, technically the money was paid back into the originating account. No claims were ever actually paid from the operating account. Most clients were not aware of this practice, although some were. I inquired about this and was told it did not matter because the clients were benefitting because the fees that would have been associated with maintaining and operating the account would always be greater than the interest that would have been earned.

NCAS received a detailed monthly report from the bank. It outlined all of the operating account's bank fees and interest. However, none of the claims accounts showed any

transactions for fees or interest because they were zero balance accounts. The total interest in the operating account was offset by the fees and the remainder of the fees were paid out of the operating account. This was generally an expense of approximately three to five thousand dollars a month. I later learned that the claims funds provided by the Agency for International Development (AID) account were supposed to be in an interest bearing account because it was federal money and the contract required it. AID was unaware of this initially, and when NCAS discovered this requirement they made no attempt to inform them or pay them the interest accrued.

Because of severe cash flow problems at NCAS, the operating account was often in danger of being overdrawn and, on occasion, was overdrawn. This situation occurred when the large volume of claims paid on a given day exceeded the amount deposited by clients to pay for those claims, because the latter had been swept into NCAS's operating account. When this occurred, I would sometimes call the bank and it would allow the account to go into overdraft, counting on the assumption that more money would be swept that night and would be put into the operating account the following morning. More often though, I would move money from the Fairfax Hospital Account (FHA), which always had a deposit of $100,000. When I needed to obtain funds and I did not want to let the account go into overdraft, I would transfer the needed cash from the FHA account to the operating account and then reverse the procedure the following day. FHA was unaware this was happening. While I felt this was wrong, because it was FHA's money to use to pay their claims, as long as the money was replaced immediately, I felt no harm was being done. There was no interest paid on the FHA account. I only did the transfer from FHA if I knew it could be transferred back the next day. Otherwise, NCAS would have needed to ask for an infusion of cash. These procedures were in place when I started working at NCAS.

I do not believe NCAS had an accurate billing system for the AID account, nor did they have any type of cost accounting method that could be used to accurately assess what it cost them to administer any particular client's claims. In particular, bills to AID were largely inaccurate due to the frequent turnover of enrollees and enrollment data problems. By mutual agreement, AID was sent billing summaries, instead of more accurate bills based on current enrollees. As a result, I never felt satisified that the bills sent to AID were very accurate.

I felt NCAS's marketing department and salesmen told clients NCAS could provide certain types of data or reports that the company was unable to provide with their claims and computer systems. This resulted in extensive labor and administrative overhead to manually produce products, which was not figured into the initial capitation rate contracted with the customer. This cost NCAS a great deal of money and, in part,

helped to explain the constant losses experienced by NCAS. I feel all of the above examples are indicative of poor management throughout NCAS.

I was also aware of the sale of our branch office, NCAS Mid-West, to Joe Crowley, E. Lee Hubbard, and Charles Baker, all of whom were employees of NCAS at the time. I thought this sale was odd, particularly in light of Crowley's continued employment with NCAS and the interrelated business dealings of the two companies. Crowley was in charge of determining which expenses should be allocated to NCAS, and which should be allocated to Modern Benefits, the holding company for NCAS Mid-West -- of which Crowley was also the President. This is a conflict of interest, in my opinion.

I also know there should have been a refund after the sale to NCAS on the security deposit for the building NCAS Mid-West occupied, but I never saw the money come back to NCAS. I also believe a loan was made to the purchasers of NCAS Mid-West (Crowley, Baker, and Hubbard) from NCAS in the amount of $250,000, but I do not have any details on this transaction. Again, there seems to be a conflict of interest here. I have heard from current employees that none of the monthly Insurdata claims processing system fees owed by Modern Benefits to NCAS for the sublicensing have been paid. This amounts to a $90,000 account receivable on NCAS's books.

NCAS Insurance Agency was created as a subsidiary to allow some employees of NCAS to broker reinsurance products and receive the fees. As a TPA, NCAS is not allowed to do this. The insurance licenses of Hendren, Dave Kreager, and Chuck Baker, all NCAS employees, were used as a basis to form the company. NCAS Insurance had no employees or office space and all work which was booked through the company was performed by NCAS. They did however, have a separate tax ID number.

NCAS Insurance was profitable, since it essentially collected fees for sales and had no overhead or expenses. Mr. Hendren directed that 97% of NCAS Insurances's profits be allocated to pay for overhead NCAS provided to the agency. The 97% breakdown was acheived by taking the monthly income from the agency and subsequently expensing it to the agency by percentage. For example, if 15% of NCAS's expenses were salary, then 15% of the 97% agency income was charged to salary and so on. However, there was no basis in fact for this figure, as there was no cost accounting, time sheets, or records completed to assess the time expended and work done by NCAS employees while performing NCAS Insurance business.

Sue Hollrith, my boss at one time, established a system to more appropriately allocate expenses for the agency. This was done by expensing ~~Baker~~ Hubbard's salary (he worked solely as an agent), a portion of Hendren's salary, and any other directly attributable expenses to NCAS/IA. Hendren was informed of this

system and he indicated that if the result were the same (the agency made a minimum profit), then it was acceptable to him. I believe this was simply a way for NCAS to take NCAS Insurance's profits and offset their losses.

While at NCAS, I was also very concerned about the fact that NCAS management received bonuses, even though our company never made a profit. Moreover, this occurred while lower level employees were being laid off. These bonuses ranged from $100 to $3000 a quarter and depended on the employee, their job, and their performance. I know Hendren and Crowley received bonuses, but these were paid by GHMSI and I did not see what they amounted to. I also am aware Hendren, Crowley, Kreager, and a fourth person had memberships in a business club, the Tower Club. The memberships were about $80 a month, for a total of about $4000 a year. I do not feel these were justified in light of our continuing losses. Kreager, and Baker also received car allowances. I know ~~Hubbard's~~ cost approximately $300 a month, but am not sure how much Kreager's cost.

I am aware of the fact Crowley's wife worked at a travel agency and all of NCAS travel was through this agency, although I was not particularly concerned about this, because I thought any vendors the executives wanted to use was their preogative. In addition, Hendren's wife's photographs were in the desk calendars that NCAS provided to all clients and employees every year. The company that published the calendars was Starwood Publishing. I have no idea if Mrs. Hendren had any interest in the company. Most all of the artwork on the walls at NCAS were photographs shot by Mrs. Hendren. At one time, Hendren asked me for information regarding the amount paid to Starwood Publishing. He said he needed it to report the conflict of interest. I do not know what the report was and it was never mentioned again.

In conclusion, I believe that in large part overall mismanagement of this company caused the losses that occurred year after year. Management's unwillingness to address and correct problems in AID billing and cost accounting for NCAS Insurance, as well as questionable procedures in preparing budgeting and forecasting data, created a situation where the bottom line was unreliable and the means to accurately obtain financial projections were disregarded. I left the company because I could no longer work in an atmosphere filled with what I considered to be dishonest and questionable conduct on the part of Hendren, Crowley and others in senior management. Management's actions were done for their own self-interest and to protect themselves from scrutiny from the parent, and were a detriment to the company and it's clients.

I have read, reviewed, and initialed each page of this statement consisting of ~~11~~ pages, and I affirm, to the best of my knowledge, belief, and recollection, that the statements contained herein are true and correct.

Teri Feider

Sworn to and subscribed before me
this 27 day of January, 1993.

Notary Public

My commission expires:

Feb 28, 1993

EMPLOYEE	DEPARTMENT:	EMPLOYMENT DATES
Teri Feider	POSITION: Sr. Acct.	FROM 11/14/88 TO 11/5/91

Senate Permanent Subcommittee on Investigations
EXHIBIT # 90

1. Why are you leaving (check one or more)

Better job opportunity	____	Family circumstances	____
Type of work	____	Maternity	____
~~Rate of pay~~	____	~~Health~~	____
Commuting distance	____	Return to school	____
Supervision	____	Other, specify	X

Please comment I find the atmosphere that pervades at NCAS intolerable. It is impossible I have found that ~~it is impossible~~ for me to work with/for people I cannot respect. Currently, I have nothing but disrespect for all of my superiors

2. If leaving for another position, what is the name of the company and what does the new job offer to you that your position with us did not?

N/A

3. What did you think of NCAS on the following points?

	Almost Always	Usually	Sometimes	Never
Demonstrates fair and equal treatment	____	____	X	____
Provides recognition on the job	____	____	X	____
Develops cooperation	____	____	X	____
Resolves complaints and problems	____	____	X	____

Please comment In my observations, promotions and recognition are made based on many considerations. However these considerations are most often not based on experience or job qualification

4. How would you rate the following:

	Excellent	Good	Average	Poor	No Opinion
Under most recent office structure					
Cooperation within my work group	____	____	____	X	____
Cooperation with other areas of the company	____	____	____	____	X

5. a. Would you say that communications from your supervisor/director were:

Excellent ____ Good ____ Fair ____ Poor X

b. Would you say that opportunities to communicate with your supervisor/director were:

Excellent ____ Good ____ Fair ____ Poor X

6. a. Did your training provide you with enough information regarding:

N/A

	Yes	No	To Some Extent
Job Duties	____	____	____
System features	____	____	____

b. What additional training would have been helpful? ____

Do you feel that your job satisfaction was:

Excellent ___ Good ___ Average ___ Poor X

Why do you feel the way you do? I have always felt that NCAS' management interests did ~~to~~ not lie in the interest of NCAS or its employees. However, in recent months it has become =>

. When you were first hired, what impressed you the most: _____

Vanessa Kinney

. Has your impression changed? If so, how? _____

3. How do you feel about the following benefits:

	Excellent	Good	Average	Poor	No Opinion
Rate of Pay	___	___	X	___	___
Paid Holidays and Vacations	___	___	X	___	___
401(K) Plan	___	___	X	___	___
Flexible Spending Plan	___	___	X	___	___
Life Insurance	___	___	X	___	___
Health/Dental Insurance	___	___	X	___	___
Annual Leave	___	___	X	___	___
Flextime	___	___	X	___	___

b. Please comment if you have rated the above benefits "Average" or "Poor".

c. What additional benefit(s) do you feel the company should offer? _____

What would have influenced you to stay? _____

Please indicate additional comments or recommendations about your job, department or the company. _____

Employee's Signature

11/8/91
Date

****

TION: If you do not wish to fill out the above information, please sign below.

Employee's Signature

Date

13 too apparent for me to ignore any longer. I'd have heard lies ~~out~~ from some members of management and lying is something I find unforgivable. I hear ~~many~~ management telling employees that times are tough and we have to cut back. Yet, they still receive perks such as Tower Club memberships, car phones, autos, golf outings and bonuses. In my opinion, this is no way to run a company.

If an employee attempts to right any wrongs at NCAS, they no longer are welcome. That has been made abundantly clear. The way Sue Hallrith's departure was handled was despicable and embarrassing. Not only for her sake, but also for how the accounting department was treated. We were left in dire straits without a suitable replacement. I don't consider a person with 6 weeks supervisory experience a suitable replacement for a person with 10 years experience.

On a specific level, I would just like it to be known that after I examined the AID claim and found it to be utter garbage, I realized that NCAS does not uphold honesty & accuracy in high regard. I cannot fault Ross on the preparation of the claim. He simply did not know the company well enough. And if NCAS defense is ignorance on their part, then they are either lying yet again, really are ignorant, perhaps too ignorant to be managing ~~from~~ of this size.

In short, my feeling towards NCAS & this. I had some really good directors during my 3 years. They ~~sh~~ did however shield me from the unpleasantries that prevailed above. So to their credit, I learned alot, enjoyed my job and I'm thankful for the experience to have worked for them. Now, I consider NCAS slime on my hands that I need to wash off, so that I can get on with my life and hopefully have the opportunity to work for and with people with honesty & integrity.

NATIONAL CAPITAL ADMINISTRATIVE SERVICES, INC. (NCAS)/AGENCY FOR INTERNATIONAL DEVELOPMENT (A.I.D.)

We have reported to the board in the past on the claims NCAS has filed against A.I.D. and the likelihood of a lawsuit regarding those claims. A report on the current status of that matter is attached to this report.

Respectfully submitted,

J. P. Gamble
Chief Executive Officer

MEMORANDUM TO: J. P. Gamble

FROM: W. G. Hendren W. G. Hendren

SUBJECT: Agency for International Development (A.I.D.)

DATE: July 7, 1992

Proposals have been submitted by both the Justice Department and NCAS for resolution of all outstanding claims between the Government and NCAS in connection with NCAS' contract to administer the Office of International Training Health and Accident (HAC) Program for 1988, 1989, 1990 with two optional years of 1991 and 1992.

After complaining to the A.I.D. Contracts Officer and Technical Manager in 1988 that the scope of the project was considerably wider than the RFP had described, and would be more expensive to administer than the fixed-price contract would reimburse, we were counseled to perform the work and pursue added compensation. We received advice from Hogan & Hartson with regard to compiling claims for equitable reimbursement in situations like ours, and were encouraged to prepare a claim.

NCAS submitted a claim for an equitable adjustment for 1988 in March 1989, and received additional compensation of $321,553 in November 1989. The contract officer, Ed Thomas, who is now deceased, indicated that a similar claim would need to be prepared for 1989. So, in March 1990, we submitted a claim for $194,772 (covering the additional expenses in 1989) and $199,624 prospectively for 1990. (It has never been paid). In 1992, the A.I.D. failed to timely notify NCAS of the intent to exercise the option year, and a separate agreement was then negotiated for six months.

The essence of the NCAS claim is that the work required exceeds the original specifications due to a failure by the A.I.D. to live up to its duties to supply clean data under the contract. The claim amount is based on the best estimate we could make of the extra labor and overhead expense incurred at NCAS due to the deficiencies on the part of A.I.D. Ed Thomas, as well as the Technical Managers, encouraged NCAS to perform the expanded scope of work and submit a claim for reimbursement of the added expense (as opposed to NCAS' restricting the level of work to the literal contract and doing a lower-quality job).

The Justice Department takes the position that NCAS willfully misrepresented the claim to the contract officer. Their theory is that NCAS deliberately low-balled the bid in order to get the award of the contract, and then contrived a rationale for submitting the claim for equitable adjustment. Part of their evidence for this deduction emanates from the admittedly faulty arithmetic that was used in preparing the 1990 claim, in which labor hours were extrapolated inappropriately.

NCAS operated under the belief throughout 1989, 1990 and the first half of 1991 that A.I.D. wanted to settle this claim fairly. However, the retirement of Ed Thomas and the opportunism of the Qui Tam relator altered that perception. The Technical Managers, who to this day profess their satisfaction with NCAS as a vendor, are helpless to intervene now that the Justice Department has accused NCAS of civil fraud.

The Justice Department is essentially self-deluded in this matter. However, by introducing an added risk to GHMSI should the matter proceed to trial and result in contract debarment, they have leveraged their position to extract a settlement.

To summarize, we currently have a $394,396 receivable from 1989 and 1990. The Justice Department proposes not paying that, and additionally fining NCAS $407,000 for the false claim in 1988. 1991 has not been mentioned. NCAS' attorney countered with a settlement offer of $315,000 last week. Therefore the liability is from $709,396 to $801,396 at this time.

The NCAS claims are reasonable and defensible, and the principal government witness (Ed Thomas himself, the only one who could deny that he encouraged this course of action) has died. Nevertheless, litigation carries a potential legal expense of $225,000 and the exposure of GHMSI to the risk of debarment from Federal contracting.

AFFIDAVIT OF
GILBERT SCOTT MARKLE

1. I am 52 years of age, a resident of the Commonwealth of Massachusetts, and reside in Worcester County at Barre and Stoddard Roads, North Brookfield.

2. I have educational degrees from Rensselaer Polytechnic Institute (B.S., Physics, 1961), the University of Paris (Doctorat d'universite, Philosophy, 1963, as a Fulbright Scholar), and Yale University (Ph.D., Philosophy, 1968). During the years 1966 through 1973, I served as Assistant and Associate Professor of Philosophy, with tenure, at Clark University, in Worcester, Massachusetts.

3. In 1965, I founded an educational travel company called "ALSG," (the American Leadership Study Groups, Inc.) which company sponsored overseas study trips for high school students, and for their teachers.

ALSG quickly became a profitable and successful business. Since 1965, the company has sponsored the travel of approximately 150,000 students and teachers, with aggregate revenues in the vicinity of $200 million.

4. In 1973, I purchased a rural property in North Brookfield known as *Long View Farm,* which would serve as the principal residence for me and my family for nearly twenty years, and as a recording studio catering to rock musicians. *Long View* became very well known during the seventies and eighties, with a client list including artists such as The Rolling Stones, Aerosmith, Arlo Guthrie, the J. Geils Band, Cat Stevens, Graham Nash, and many others.

At or about that same time I purchased a beachside property in Truro, Massachusetts known as the *Boathouse*.

5. In 1986, subsequent to the American bombing of Tripoli and the various threats of terrorism abroad, ALSG experienced a sudden and devastating cancellation of thousands of students then planning to take summer trips overseas. Approximately 4,000 such students cancelled their trips, demanding that all sums be returned, sometimes at variance with published ALSG refund policies. Unable to make such refunds, I mortgaged the homes described above and borrowed money commercially in order to make the repayments to students, which were all eventually made.

6. In July of 1986, administrators of ALSG were approached by representatives of Access America, Inc. ("Access"), which at that time was a recently-created, for-profit subsidiary of two East Coast Blue Cross and Blue Shield insurance "plans." Access was marketing a new insurance product to tour operators such as ALSG which promised refunds to travelers in the event their trips were cancelled due to unforeseen circumstances, such as a terrorist attack in foreign cities about to be visited.

ALSG purchased this insurance from Access for the upcoming 1987 travel season on behalf of its clients, hoping to restore consumer confidence in overseas travel, and to reduce consumer anxiety on the topic of cancellation penalties.

I did not meet personally with any representatives of Access in 1986, and approved the purchase of the insurance upon the strong recommendation of my subordinates.

7. In 1987 the student travel industry failed to rebound, and ALSG found itself unable to operate its summer tours for a lack of money. I had by that time exhausted all sources of financial support, including banks, commercial lenders, and so forth. On or

about May 20, 1987, I advised Access that ALSG would shortly be obliged to suspend service to its clients who, under the terms of their insurance coverage, would probably seek eventual relief from Access. The exposure to Access and to its underwriter, the BCS Insurance Company, was then estimated to be approximately $8,000,000.00.

8. Under the circumstances, and in an effort to minimize its own liability and that of BCS on these individual policies of insurance, Access agreed to secure ALSG obligations with letters of credit, and other financial instruments, in order to avoid default on the part of ALSG.

Approximately $2,300,000.00 in credits were advanced to ALSG at this time and, in return, ALSG and I executed various documents securing the repayment of these sums to Access. In these documents, mortgages on ALSG-corporate and my own personal assets, including mortgages of the *Long View Farm* and the *Boathouse* real estate properties, were delivered to Access.

9. In 1988, the continuing deterioration of the travel industry worldwide was reflected in mediocre financial performance on the part of ALSG. Nevertheless, ALSG was able to make substantial repayments of sums borrowed from Access, and the total outstanding loan balance at the end of calendar year 1988 was actually less than in 1987.

10. In July of 1988, I informed the President of Access, Mr. Edward S. Shulman (hereinafter "Shulman"), that additional short-term reborrowings would be required in order to fund the travel of students overseas. Shulman and an assistant arrived at ALSG's headquarters in Spencer, Massachusetts, and determined that additional cash infusions were in fact necessary for the continued operation of ALSG. These additional borrowings were arranged with the

financial support of Access in cooperation with BCS, and, as a condition of this additional financial assistance, Access required that I pay into ALSG the proceeds of my profit-sharing fund, then amounting to approximately $70,000.00, to be repaid at a later date; that I take out a loan on my automobile and pay this into ALSG, to be repaid at a later date; that I pay into ALSG the contents of savings accounts in the names of my children to be repaid at a later date; and that I execute the so-called Modification Agreement dated July 13, 1988. In said Modification Agreement, I transferred to Access the right to vote, sell, or otherwise transfer the ALSG stock which had been pledged to Access.

None of the repayments to me, or to my young children, was ever made.

11. Subsequently, Shulman and other Access staff were frequently present at the offices of ALSG. Shulman explained to me that the effect of the Modification Agreement would be that ALSG "*would now be his* [Shulman's] *company.*" From that point on, after July 13, 1988, and in an apparent attempt to protect the loans of Access, Shulman exerted substantial control of ALSG and formulated most of the financial policy decisions of the company.

12. Throughout 1988 and into 1989 Shulman continued to be present at ALSG, setting not only financial policies but also sales and marketing policies, and handling employee matters as well. I found many of Shulman's policies to be unwise and not in the best interests of ALSG and so complained to Shulman. These policies included precipitous reductions in mail and telephone marketing budgets, on which ALSG depended for at least half of its business each year, and capricious personnel cuts. I have since testified that Shulman's policies resulted in predictable and disastrous declines

in student enrollments, and redoubled financial losses for the company.

13. Following Shulman's arrival at ALSG and at least in partial result of his imprudent financial and marketing policies, ALSG's total borrowing needs rose to $5,400,000.00 before the end of the 1989 calendar year. This was a substantial and dramatic increase over the borrowings that ALSG had made from Access during the prior two years, during which time the overall loan balance had actually declined.

14. In May of 1989, Shulman demanded of me that I deed over my two homes, *Long View Farm* and the *Boathouse,* to Access. When I declined to take such action, Shulman stated that, *"Mark my words, if you don't* [deed over the properties], *they will say what they have to say, get a judge and force it down."* He emphasized that I did not realize I was up against Blue Cross & Blue Shield, and that I *"could not win"* in a legal confrontation.

15. By the summer of 1989, Shulman was making virtually all financial, marketing and personnel decisions at ALSG, and my role was reduced to a mere figurehead presence. For example, in formulating the 1989 year-end figures to be provided to the ALSG auditors, Peat-Marwick, Shulman dealt only and directly with the ALSG corporate controller, Ron Plasse (hereinafter "Plasse.") I have since testified that during the months in which this year-end audit occurred, Plasse complained to me frequently that he *"was under pressure from Shulman to come in at or beneath a certain number."* Shulman was at that time the President and Chief Executive Officer of Access America, Inc.

16. Shulman's employment at Access was apparently terminated shortly thereafter. I believe that Shulman's communications with his corporate superiors was never good insofar as it related to

ALSG, and that he was always hopeful that he could "solve the problem," on his own, before it came more fully to their attention.

17. ALSG and Access continued to communicate relative to the outstanding financial problems through their chosen legal counsel. After much negotiation, I was persuaded to execute stock powers of my stock interest in S.E. Music, TSE, ALSG, Myles Travel Bureau, Inc. and Worcester ChartAir, and to execute deeds to the *Long View Farm* and the *Boathouse* real properties, within the context of a May 9, 1990 agreement which would convey certain repurchase rights and other benefits to me. Pending the finalization of that Agreement, the documents executed by me were to be escrowed.

18. However, Access acted upon the stock powers and recorded the deeds to my properties immediately, contrary to written understandings between the parties, and with no notification to me. These actions became the subject of renewed disputes between me and Access. Thereafter, additional and new resolutions of all outstanding issues between Access and me were proposed, and a "final" Settlement Agreement was signed by the parties on October 23, 1990.

19. This Settlement Agreement was designed to settle, once and for all, grievances that I had against Access for its unauthorized and wrongful appropriation of my real estate properties and stock interests in violation of the earlier May 9, 1990 Agreement; to release me of all personal liability to Access above and beyond my real property interests in *Long View Farm* and the *Boathouse*, and my stock interest in five (5) Massachusetts corporations, This is Something Else, Inc. (TSE), S.E. Music, Inc. (SE), Myles Travel Bureau, Inc., Worcester ChartAir, Inc. and American Leadership Study Groups, Inc. (ALSG); to provide me an agreed-upon manner and terms according to which I could repurchase both my real estate assets and stock interests, which manner of purchase had been prom-

ised to me in the May 9, 1990 Agreement but never delivered; to provide me with compensation through May 8, 1992, at an annual rate of $100,000.00 per year, which level of compensation had also been promised by my earlier Agreement of May 9, 1990, but never delivered; to provide me with full authority and right to operate the recording studios and businesses at *Long View Farm,* during the term of the Settlement Agreement, which was to be 120 days.

20. Following the execution of the October 23, 1990, Settlement Agreement, I diligently attempted to raise capital and to promote interest of various investors in the prospect of financing and/or investing in the repurchase of the real estate properties and corporations conditionally transferred to Access.

21. However, following the execution of the October 23, 1990, Settlement Agreement, Access took various actions meant and designed to frustrate my ability to repurchase my real properties and stock interests. This was done by including large debt obligations within the purchase price for the reconveyance, and by utilizing current client deposits to defray operating expenses of the ALSG business, each action contrary to express terms and conditions of the Settlement Agreement, and which together effectively increased the "real" purchase price as made to me from $3.4 to $6.7 million. Such debt obligations were not made a condition of purchase of any other third party purchaser and, indeed, were not made a condition of the purchase of the eventual third party purchaser, a Mr. Sam H. Cooper ("Cooper"), who purchased the properties allegedly on behalf of La Jolla University with a simple promissory note in the amount of $3,400,000.00. (See below.)

22. Additionally, Access deliberately failed to provide me duly-requested due diligence materials such as a "Seller's Balance Sheet," and denied me access to my executive notes, memos, analy-

ses, business plans and other materials necessary to market the assets. I was not allowed on the ALSG offices premises, and was disconnected from the computer systems which I had designed over the years, and in which all relevant information was stored. Further, Access intentionally failed to provide me with items of computer hardware and software due to me under specific provisions of the Settlement Agreement for the purpose of marketing these same assets.

23. Access also sought to vilify me personally during the term of the Settlement Agreement, particularly in the eyes of my former business associates and employees. James Gibson (hereinafter "Gibson"), an employee of ALSG's during the term of my Settlement Agreement, later testified that on a day-long business trip in January, 1991 to Long Island, New York, in the company of Jon Ansell ("Ansell"), the newly-appointed C.E.O. of ALSG for Access America, and a signatory to Markle's Settlement Agreement, Ansell boasted that the price of re-acquisition of the assets, to Markle, was in fact *"not finite,"* that *"Gil should end up with nothing, and I'm seeing to it,"* and that *"I've met hundreds of people like Gil before, and enjoy teaching them a lesson."*

24. It is significant that Ansell was not just a signatory to my Settlement Agreement, and hence fully familiar with it, but was also in charge of the subsequent day-to-day implementation of that Agreement, as involved meetings with my team of advisors on the topic and interpretation of that Agreement, the satisfaction of due diligence requests, the provision to me of computer hardware and software, pronouncements on matters of antecedent debt and the use of student funds by Access to defray operating expenses, and other provisions of the Agreement which, as I have alleged, were deliberately and willfully frustrated by Access, in evidence of the very

sort of ulterior motivation and malicious intent which Gibson heard expressed by Ansell during the Long Island business trip.

25. I believe that Access at all times acted in breach of its Settlement Agreement of October 23, 1990, and in an effort to frustrate my contractual rights to repurchase my properties. Said actions of Access were successful.

26. On February 19, 1991, still within the term of my option agreement with Access, Access reached a hasty in-principle agreement with one Sam H. Cooper, from Tennessee, for the purchase of the corporate and real property assets for $3.4 million in promissory notes. No cash down. A closing with Mr. Cooper was had approximately one month later. There is reason to believe that, during the intervening four weeks, Access performed little or no "due diligence" as concerns the credentials or the actual financial resources of Mr. Cooper.

27. Access did not respect the terms of its "parachute" agreement with me during this interim period, allowing insurance policies to be cancelled for me and my family, and by going slow on interest payments to BayBank, resulting in the default and acceleration of a mortgage loan paid into ALSG in 1987 by me, and in the eventual bank foreclosure on the property in which my children live. (See below.)

28. Access vilified me repeatedly to the new management at ALSG, successfully limiting my involvement in the firm which I had created 26 years earlier.

29. During this same interim period, I continued in my financial support of the recording studio at *Long View Farm,* because nobody else would, and this support amounted to over $26,000 during a six-month period beginning in April, 1991. Access was informed by

me and by my attorneys of this financial support for *Long View*, and raised no objection. Access was also told that I was still a ready and willing buyer for the properties, which had been my residences for nearly a quarter of a century, and did not object to this either, acknowledging that I was "perhaps the only buyer for them."

30. In July of 1991, upon the default on the part of Mr. Cooper to make certain payments to Access, and in the light of Mr. Cooper's apparent inability to fund the travel plans of several thousand ALSG students about to depart (or already departed) for Europe, Access sought and received Court approval for the appointment of an ALSG Receiver, one William Gabovitch ("Gabovitch"), which Receiver Access agreed to temporarily fund, **provided that Access would henceforth be the sole secured creditor of the Receiver.**

31. Access commenced legal action against Cooper at this time, claiming fraud, and the misappropriation of corporate funds.

32. In September of 1991, the ALSG Receiver, Gabovitch, sold the ALSG assets to a British firm for approximately $800,000.

33. In October of 1991, in the context of an interim Settlement Agreement with La Jolla University, a Cooper organization, and in an apparent violation of a San Diego Court order prohibiting any further alienation of the real property assets, Access repurchased *Long View Farm* and the *Boathouse* from La Jolla for $10 each.

34. Immediately thereafter, Access attempted to evict me from these two properties, using *ex parte* court orders. However, I refused to leave, citing a lack of Summary Process. In court, two days later, Access was granted a Restraining Order by which I was temporarily restrained from entering upon the *Boathouse* or *Long View Farm* premises, my homes for over two decades, save for a small

apartment in the *Long View* barn which, as it turned out, I would continue to occupy, under highly stressful conditions, until September of 1992.

35. At or about the same time, Access sought and received Court approval for the appointment of the ALSG Receiver, the same William Gabovitch, as the Receiver for the *Long View* recording business. The Receiver immediately laid claim to all the equipment and personalty on the premises of *Long View*, which I claimed to own personally, and brought an action against me on behalf of the ALSG Receivership Estate, of which Access is the sole secured creditor, in an attempt to recover for Access sums which it, Access, had already released in the Settlement Agreement. Access was prepared to take back with one hand that which it had given with the other.

36. Then, in a similar effort, the Receiver seized personal bank accounts in which my remaining and modest savings were stored, including sums earned at the recording studio during the term of and in accordance with the provisions of my Settlement Agreement with Access, compensation payments paid to me by Access in accordance with that same Settlement Agreement, and rent payments from my tenant at the Spencer Office Building, which happened to be ALSG.

37. Shortly thereafter, when it became clear that I was prepared to defend myself against these actions, which I insisted were at variance with the provisions of my Settlement Agreement with Access dated October 23, 1990, and in total repudiation of that written Agreement, Access terminated the payment to me of the bi-weekly compensation and medical insurance checks for me and for my two children, and for their mother, as provided for in *Par. 4(b)* of that Agreement.

38. There is no doubt in my mind that these and other actions were performed by Access in an attempt to render me financially destitute, to starve me out of a long-standing residence which I refused to leave, and to make it impossible for me to finance my legal defense.

39. Access attempted to intimidate me by other means as well. Beginning on October 29, 1991, and continuing for almost a year's time, I was continuously harassed by the Receiver, his agents and attorneys, and/or Access personnel, agents of Access, and attorneys for Access. Armed guards and agents paid by Blue Cross & Blue Shield moved onto my residence, *Long View Farm,* and roamed the premises, sometimes with specially-trained dogs and surveillance devices, and deliberately interfered with my property rights, my rights to receive communications, including mail and telephone calls at my residence, and intentionally interfered with my privacy. I have evidence suggesting that my telephones were tapped during this period of time, and/or that listening devices were applied to the outside walls of my apartment, presumably by agents of Access.

These actions constituted virtual house arrest.

40. Such agents of Access also harassed the caretaker at the *Boathouse,* instructing him to quit the premises, contrary to my wishes, and ignoring all considerations of safety for this particularly vulnerable real estate property and for my possessions within, and absent any provisions or procedures of Summary Process eviction. (See below.)

41. Finally, the Receiver, agents of the Receiver, agents of Access, or agents of Access' attorney misappropriated my personal property, which property is owned exclusively by me and located at

Long View Farm and the *Boathouse*. These items were promptly taken over by *Long View Farm* staff, who were by now employees of the Receiver, as their own personal possessions, and have been used as such ever since, with the full knowledge and approval of Access. These items include such things as my wedding gifts, family heirlooms, bequests from recently-deceased grandparents, items of clothing, my pets and animals, my books and papers, dishes, towels and household furnishings, sundry personal possessions which I brought onto the *Long View* premises in 1973, and perhaps most importantly, my recording equipment and media archives.

42. I believe that Access and the Receiver performed these actions willfully and knowingly in furtherance of malicious and/or ulterior motive or purpose, and have engaged in violations of law such as self-help in the eviction of persons peacefully in possession of property, harassment, and the intentional and negligent infliction of emotional distress.

43. My dispute with Access America was brought to trial at the Worcester Superior Court in March of 1992, consolidated under docket numbers 91-3222, 91-3223, and 91-3471. The trial went badly, and was dominated from the beginning by the numerous attorneys for Access, who smeared me viciously in Court and in the local press, citing alleged events pre-dating my Settlement Agreement, and pre-dating Access' involvement with ALSG, by many years. My attempts to introduce similar contextual data bearing on Access' mismanagement of ALSG affairs were all unsuccessful. Nothing before or after the term of the Settlement Agreement brought forward by my attorney made its way into evidence. The eventual trial Exhibits consisted mainly of documents brought forward by Access.

I believe that the Worcester Court was impressed and intimidated by the presentation by Blue Cross, which was expensive,

ruthless, and extremely well-staffed. I appeared with one attorney, whom I was unable to pay, and was obliged to personally draft and type most trial pleadings, to prepare witnesses, and so forth.

44. Post-trial motions went badly as well, with my attorney unable to reopen evidence, to submit new evidence, to adduce documents bearing on the comprehensive nature of the Releases, or to recover any of the substantial sums owed to me by Access.

45. Access continued in its policy of personal harassment during this post-trial period, and made regular attempts to entrap me in apparent violations of Court restraining orders, which Access would interpret and reinterpret to suit its purposes. For example, I was arbitrarily forbidden by Access to speak with any persons at *Long View Farm,* which has always been my home, for any reason, including friends known to me for twenty years or more. My mail was opened, my calls screened, my visitors interrogated, and my conversations spied upon.

46. Hoping always to strike a deal with Access and to settle, I approached Washington, D.C. higher-ups in May of 1992, suggesting that Access name a price and give me an interim chance to repurchase my homes. However, Access promptly cited me in court for Contempt for these efforts to settle, having first encouraged these efforts, and was joined by the Receiver in Court who simultaneously cited me for Contempt for alleged and wildly trumped-up charges of "interference" with the recording studio operations. False testimony was introduced against me, including the charge that I was holding myself out before studio clients as a famous Australian record producer.

A "deep throat" informant later confided to me that the Contempt charges were all deliberately fabricated by Access and *Long View* staff, and by legal counsel for the Receiver, in an

attempt to influence the trial decision, which was still pending at that time before the same magistrate.

47. In September of 1992, the trial judge handed down her verdict, which was unfavorable to me on every point. In particular, the ALSG Receiver, whose sole secured creditor is Access, was allowed a judgment against me of over $400,000, despite the fact that I was released by Access and its affiliates (including ALSG) by my Settlement Agreement of October 23, 1990.

48. My attorneys filed post-judgment motions, including a request for a new trial, citing multiple erroneous findings totally unsupported by evidence. These post-judgment motions are currently pending.

49. In the meanwhile, the Access *Receiver* has attached the remaining sums owed to me by its sole secured creditor, Access, which have allegedly been escrowed by Access in its attorneys' account. Access would of course be the sole beneficiary of any such award, doubly circumventing the provisions of its earlier agreements with me by which I was released from any such debt, and promised certain cash payments during an interim period. Incredibly, the attachment was allowed.

50. Also in September of 1992, BayBank moved to sell by foreclosure the house in which my children live, *Farmers' Hall*. It was this mortgage loan which Access caused to be accelerated in 1991 by the non-payment of interest charges, as called for by its Agreement with me.

The proceeds of the *Farmers' Hall* mortgage had been paid into ALSG by me in 1987 as a loan in an attempt to salvage the finances of that company. The loan has never been repaid. The *Farmers' Hall*

property is presently scheduled to be sold at auction by the bank on January 29, 1993.

I have been told by the attorney for the Bank that a likely bidder at the auction will be Access America itself. I wonder aloud what use this subsidiary of a Washington-based Blue Cross & Blue Shield insurance "plan" will find for the ramshackle Massachusetts house in which my children live.

51. In December of 1992, I received reports from neighbors, friends, and from local police officials in Truro, Massachusetts that my home, the *Boathouse,* had been severely damaged in a winter storm, and that its doors were blowing open, and that it had apparently been visited by thieves. Further inquiries revealed that, despite repeated warnings from me that this home was exquisitely vulnerable to the elements, and that it contained many valuable personal possessions, Access had left this home at the mercy of the elements, and the Atlantic Ocean, failing to fit shutters, storm doors, and hatch covers. As a result, part of the roof blew off, extensive water damage occurred, the doors blew open, and the house was vandalized. Access has denied any responsibility for these events, through its attorneys, and has threatened to take legal action against me if I attempt to protect this property, or my possessions remaining within it, in any manner. My own attorneys have recommended that I file an immediate and further Complaint against Access, alleging deliberate disregard for real property in dispute and for my personal possessions.

52. I do not believe that the legal system miscarries indefinitely, and am confident that a full airing of the events at ALSG during 1987-1991 will establish that Access acted irresponsibly as a lender, hoping to accelerate the term of repayment of sums owed to it by ALSG, that Access itself created by its own actions the

lion's share of the losses posted by ALSG during these years, and that in any case the attempts of Access to see itself repaid sums for which it would otherwise have been responsible as a once willing and eager insurer of travel products amounts to a concealed policy of insurance claims avoidance.

I also hope to establish that Access, at great expense to its parent companies, has acted against me and my family in a vengeful, conspiratorial and illegal manner, which on-going actions I am prepared to continue to resist, and to bring to light, in the hope of seeing such policies publicly censured and reformed.

Submitted under the pains and penalties of perjury, Wednesday, January 20, 1993.

Gilbert Scott Markle

ADDITIONAL QUESTIONS FOR THE HEARING RECORD

Question No. 1

REDACTED FOR REASONS OF PATIENT PRIVACY

Question No. 2

The Subcommittee has received complaints from consumers who said they were forced to purchase life insurance from GHMSI's life insurance company as a precondition for health insurance being provided by BCBSNCA. This activity was confirmed by the Subcommittee's Staff. Is this practice legal? Should persons desiring health insurance coverage be forced to purchase life insurance from the same company?

Answer

Pursuant to an agreement between GHMSI and NCIA, it has in fact been the practice to package life and health insurance when selling to small groups. Such an arrangement is common in the insurance industry, where commercial carriers routinely package insurance in this manner in an effort to boost sales. In addition, commercial carriers use the life insurance premium to help subsidize the health insurance, which GHMSI is unable to do. GHMSI has never required its individual, nongroup subscribers to purchase life insurance.

As a result of the Subcommittee's inquiry about this matter, however, GHMSI has asked counsel to

review the matter, and intends to explore any appropriate alternatives identified by counsel.

Question No. 3

When did the Board learn that the National Association had placed the Plan on conditional membership status?

Answer

Mr. Gamble told the Board of Trustees ("the Board") in the May 7, 1989 Board meeting that GHMSI was "in good standing" with respect to its compliance with membership standards of the Blue Cross and Blue Shield Association (the "National Association"). Minutes of the Meeting of the Board of Trustees of GHMSI, May 7, 1989, at 5. While the relationship with the National Association was discussed in general terms thereafter, it does not appear that the Board learned that GHMSI had been placed on conditional membership status until July 10, 1990, when Mr. Gamble informed the Board that the Company had been placed on such status as a result of insufficient reserves. Minutes of the Meeting of the Board of Trustees of GHMSI, July 10, 1990, at 4. In February 1992, Mr. Giuliani informed the Audit Committee of the Board that GHMSI had been placed on the National Association's "Watch List." The Trustees received the minutes of this Audit Committee meeting in preparation for the Board meeting of March 18, 1992.

Question No. 4

This question was withdrawn.

Question No. 5

At a time when health insurance premium charges to D.C. subscribers were being increased, and coverage was declining, you engaged in multiple ventures with foreign insurance companies. In those ventures, you accepted anywhere from 50% to 100% of the risk that these foreign insurance carriers wrote overseas. Why, for example, did the DC Plan feel it necessary, or its duty, to insure Russian, Polish, Mexican, Panamanian, and Indonesian citizens -- to name a few -- when they travelled outside of their countries? Have you made money on these ventures?

Answer

In reading this question, it is disturbing that the Subcommittee refers to "coverage" as "declining," just as it was disturbing to hear similar phrases during the Staff testimony at the hearings. While this phrasing suggests that GHMSI is somehow reducing the benefits we provide, GHMSI is not aware of any such reductions, and the Subcommittee has not cited specific examples.

In any event, GHMSI has taken numerous actions not because they are deemed "necessary" or "its duty," but because the Company has believed the actions either would benefit subscribers directly, or would make good business sense and thereby benefit subscribers indirectly. Every other successful company--nonprofit and otherwise--makes business decisions in a similar way. While some of these ventures ultimately proved unsuccessful, at the time GHMSI engaged in them, it did so with the expectation that they would be profitable. There was no sense of duty or necessity other than the necessity to make money for the benefit of our subscribers.

Moreover, a number of GHMSI's ventures in the international market have in fact been profitable, specifically, those ventures in Latin America. Other programs have benefited area subscribers in different, but equally important ways. For example, GHMSI has had a long and successful record of providing benefits to foreign citizens who belong to the District's large international and diplomatic community. Likewise, for the last quarter of a century GHMSI has been proud to provide health care coverage to employees of the United States government who have served their country abroad.

Question No. 6

Wouldn't the money you spent establishing and maintaining these ventures have been better spent on providing better health insurance for the citizens of the District of Columbia?

Answer

Certainly, in hindsight it appears that the money might have been better spent, given the ultimate lack of success of many of these ventures. However, this question oversimplifies the situation. Diversification was a favored corporate strategy in the mid-1980s. Many major domestic corporations successfully diversified and many others did so unsuccessfully. GHMSI was not alone, even among Blue Cross and Blue Shield plans in seeking to diversify. Had all of GHMSI's subsidiary ventures proved profitable, as they were intended to be, those profits would have benefited local subscribers by helping to keep the cost of premiums down.

In addition, it is important to emphasize that during this period of diversification, GHMSI was not neglecting its local customers in favor of international business. GHMSI continued to improve its coverage and operations for local subscribers by implementing the FLEXX claims processing system which has streamlined the payment of claims; reducing administrative expenses as a percentage of premiums; developing new products and provider networks designed to provide consumers with more affordable health care; ensuring that all participating providers meet certain basic standards; and creating public education campaigns aimed at reducing health care costs in the long run.

At the same time, GHMSI continued to provide the quality of service that customers have come to expect from the Blue Cross Blue Shield name by promptly responding to claims and inquiries; working with local health organizations to promote access to affordable health care; determining the safety and efficacy of new medical procedures; and serving as the community's insurer of last resort as it has done for more than half a century.

Question No. 7

What control did you have over your foreign insurance company partners?

Answer

GHMSI's efforts to ensure proper control over its foreign partners have fallen into two broad categories.

First, GHMSI has worked diligently to protect its own interests in the contracting process. In this regard, GHMSI took care to deal only with large insurance companies that were registered and licensed in their country of residence. Under the terms of the legally binding reinsurance and administrative contracts between GHMSI and these companies, GHMSI retained control of rate setting, underwriting, and administration of out-of-country claims. In addition, GHMSI contracted directly with hospitals worldwide to ensure that the hospitals would send bills, along with necessary medical information directly to GHMSI.

Second, GHMSI established domestic controls over its foreign business. For example, GHMSI's medical advisers routinely reviewed questionable claims worldwide. In addition, GHMSI's claims processing staff reviewed claims expenditures on a monthly basis.

Question No. 8

The Staff testified that the Company's relationship with regulators was poor, and that the Company even refused to give complete information to regulators and to its own Association. What have you done to rectify this problem?

Answer

GHMSI is committed to cooperating fully with the National Association and the regulators in Maryland, Virginia, and D.C. and to responding promptly and completely to all inquiries. GHMSI was heartened that its efforts in this regard were acknowledged during the hearing testimony of D.C. Insurance Commissioner Robert M. Willis.

Question No. 9

The corporation allegedly violated provisions of Virginia State law by not obtaining prior approval for its major investments in subsidiaries. Did you know about those legal provisions? Why didn't you follow them?

Answer

To GHMSI's knowledge at all times the company has complied with all provisions of Virginia law. Since 1989, GHMSI reported annually any changes in the capitalization of the subsidiaries and any loans to the subsidiaries by banks or GHMSI. GHMSI did not report any increase in the amount of non-interest-bearing accounts receivable from the subsidiaries because it was GHMSI's belief that those amounts did not need to be reported.

As to recent acquisitions, GHMSI discussed its purchase of First Continental Life with Virginia authorities prior to consummation of that transaction.

Question No. 10

What is your response to the Subcommittee Staff's finding that while NCAS has never made a profit and has lost millions and continues to lose money, the salary of company President, William Hendren, rose, and that during 1990, when NCAS lost nearly $1 million, he received a $15,000 bonus, and during 1991, when NCAS lost another $840,000, Mr. Hendren's bonus doubled to $30,000?

Answer

As a start-up company, it was fully anticipated that NCAS would lose money in its early years. Mr. Hendren was charged with growing the business and growing the NCAS/Insurdata network during this time period, and he achieved those goals. Mr. Hendren's salary increases were made in order to keep his position competitive within the industry, and bonuses were paid because he achieved his goals. Mr. Hendren received no bonus in 1992.

Question No. 11

Are you aware of NCAS' policy of cash sweeping, i.e., moving funds that had been deposited by a client for paying medical claims into NCAS' own operating account. Are you aware that this practice is illegal in at least one State (Michigan) in which NCAS did business, and that NCAS failed to follow federal requirements along these same lines in connection with

its AID contract. Is cash sweeping a general BCBSNCA/GHMSI policy and, if so, how do you reconcile this with the above-mentioned questions?

Answer

NCAS clients have the option to segregate funds for paying medical claims in a client-owned account and to handle the administration of that account. That is the NCAS preferred approach and 61% of all claims paid by NCAS are paid using a client-owned account.

NCAS clients have the alternative of having NCAS directly disperse funds to pay benefit claims. For these clients, NCAS pays claims from its own operating account as they are approved and then notifies the client of the exact amount of the payment. At that point the client authorizes the transfer of funds to NCAS to repay NCAS for the funds expended on that client's behalf. Therefore, any so called "cash sweeping" from one of NCAS's subaccounts into its master account involves only funds belonging to NCAS.

GHMSI considers NCAS's handling of the funding for the benefit payments for NCAS-administered plans to be reasonable and has been advised that it complies with the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). GHMSI is aware that Michigan law requires the maintenance of separate accounts, and states that NCAS does not maintain accounts in Michigan. NCAS-Midwest, while owned by NCAS, did maintain separate accounts. "Cash sweeping" is not "a general BCBSNCA/GHMSI Policy," but cash management--investment of available funds--is performed on a daily basis by BCBSNCA. This is not a violation of law.

Question No. 12

In 1990 and 1991, at least three audits--two by GHMSI internal auditors and one by the Defense Contract Audit Agency (DCAA)--showed that NCAS' operations were being seriously affected by persistent and widespread problems. In addition, a 1991 investigation by the AID Inspector General substantiated allegations of questionable conduct on the part of NCAS in connection with claims for equitable adjustment it had submitted

to AID in 1988 and 1989. Did you know about these various audits and investigations and, if so, what did you do about the problems they revealed? Did you inform the Board?

Answer

I had no personal knowledge of or involvement in these audits and investigations. It is my understanding that NCAS took all appropriate steps to respond to the audit recommendations and to make appropriate corrections in regard to the AID investigation, outside counsel was hired and the issues were resolved through settlement of litigation. In May 1992, Mr. Gamble informed the GHMSI Executive Committee of the litigation. Minutes of the Meeting of the GHMSI Executive Committee, May 5, 1992, at 5-6. The Board subsequently learned of the litigation through its receipt of the Executive Board Minutes. Minutes of the Meeting of the Board of Trustees of GHMSI, May 17, 1992, at 2.

Question No. 13

What assurances can you give the public and subscribers that the excesses and mismanagement previously identified will not occur again, once the Subcommittee and public scrutiny is gone? What procedures have you established to ensure it? What recommendation do you have for other Plans? For the National Association? For regulators?

Answer

As our earlier submission and related testimony explained, last July Mr. Giuliani eliminated all travel and expense policies which appeared subject to prior abuses, and has tightly controlled costs and expenses since that time. Moreover, GHMSI is in the process of developing a comprehensive new code of conduct for all employees that will address many of the other practices criticized by the Subcommittee.

In addition, GHMSI fully supports the new standards announced by the National Association and will be implementing them over the next year. GHMSI currently is reviewing these standards to determine whether GHMSI is in compliance. A recommendation will be presented to the Board in March regarding any standards which GHMSI currently does not meet.

Question No. 14

As a result of breaches of fiduciary duties by the officers and trustees of unions and their health and welfare plans, Congress enacted criminal and civil penalties to address this problem (18 U.S.C. § 664). Would you support similar legislation for the officers and trustees of not-for-profit health insurance plans, who, like union officers and trustees, have a fiduciary duty for the subscribers?

Answer

Congress should focus on assuring that there is a level playing field for both for-profit and not-for-profit health insurance companies. Before enacting civil and criminal penalties directed at not-for-profit companies, Congress should consider whether doing so will place unfair constraints on a company such as GHMSI that must vie for business with unrestrained for-profit competitors. Congress also should determine whether the comparison between not-for-profit health insurers on the one hand, and unions and health and welfare plans on the other, is in fact valid. Finally, before enacting legislation, Congress should consider whether it is appropriate to apply federal civil and criminal penalties to an industry that has traditionally been regulated by the states.

Question No. 15

Has GHMSI discovered any violations of any Federal criminal code by any of its current or former officers, directors, or employees?

Answer

GHMSI has not determined that any of its current or former officers, directors or employees committed any federal criminal violations.

Question No. 16

Price Waterhouse recommended in their February 26, 1992, management letter that GHMSI

> . . . strengthen the authority and level of involvement of GHMSI's chief financial officer with GHMSI subsidiaries.

Have you taken any action to strengthen the authority of the chief financial officer over the subsidiaries?

Answer

Efforts to have been made and continue to be taken to strengthen the authority of the chief financial officer over the subsidiaries. The former chief financial officer had authority over BCBSNCA only until late 1992, when he, and his successor, were given responsibility for subsidiary oversight. The current chief financial officer has authority over all of GHMSI.

Significantly, GHMSI has been advised by its auditors that the comment which is the subject of this question will no longer appear in the management letter due to management's responsiveness on this issue.

Senate Permanent Subcommittee on Investigations
EXHIBIT # 124.

NAIC

National Association of Insurance Commissioners

Hall of the States
444 N. Capitol Street, N.W., Suite 309
Washington, D.C. 20001-1512
202-624-7790

FAX 202-624-8579 Washington Counsel
FAX 202-624-8460 Financial Analysis

March 5, 1993

The Honorable Sam Nunn
Chairman
Permanent Subcommittee on Investigations
Committee on Governmental Affairs
SR-100 Russell Senate Office Building
Washington, D.C. 20510

Dear Mr. Chairman:

Please find following answers to the additional questions submitted for the record pertaining to the Permanent Subcommittee on Investigations' hearings of January 26 and 27, 1993 on Group Hospitalization and Medical Services, Inc. (GHMSI), which does business under the name of Blue Cross and Blue Shield of the National Capital Area (BCBSNCA). I have attempted to make clear where I am answering only in my capacity as the President of the National Association of Insurance Commissioners (NAIC) and where I am replying solely as the Commissioner of Insurance for the Commonwealth of Virginia.

Q. What is the NAIC Blue Cross Committee doing regarding the problems that we have uncovered on the Blue Cross Plans?

A. The NAIC formed the Special Committee on Blue Cross Plans of the Executive (EX) Committee in 1991. Since then, the Special Committee has been working on issues involving the review and oversight of the Blue Cross and Blue Shield plans (collectively known as the "Blues" plans). For 1993, the Executive (EX) Committee has directed the Special Committee to:

(1) Study the overall regulation of Blues plans, including the public policy, legal, and business environment in which particular Blues plans operate and the differences in methods of operation, including mutualization;

(2) Develop minimum risk-based capital requirements for Blues plans; coordinate efforts with the Risk-Based Capital (EX4) Working Group;

(3) Develop a more uniform system of financial reporting for Blues plans; coordinate efforts with the Blanks (EX4) Task Force;

(4) Determine whether and how Blues plans should be integrated into the state guaranty fund systems and whether state receivership laws are applicable to Blues plans;

(5) Study whether current state laws related to corporate governance, accountability, and Blues plan acquisition of and transactions with affiliates are adequate to assure appropriate regulatory authority over such acquisitions and transactions; and

(6) Evaluate the role played by the [Blue Cross and Blue Shield] Association in the regulation and operation of member plans, including Association financial standards, the adequacy of internal discipline, inter-plan bank transactions, and enforcement of Association standards.

As far as specifically what the NAIC will do, at this point, I can only emphasize that the NAIC will strive to develop effective and meaningful minimum capital or risk-based capital requirements for the Blues plans. In addition, the Special Committee will consider applying the model holding company act to the Blues, an idea already endorsed by the Blue Cross and Blue Shield Association. The NAIC will also look at extending guaranty fund coverage to the Blues or developing equally reliable mechanisms geared to solvency protection. It should be noted that, particularly in the case of the Blues plans that are organized as mutual insurers, several are covered by guaranty funds and are required to comply with the holding company act and other financial reporting requirements. In a jurisdiction such as the Commonwealth of Virginia, a Blues plan, whether organized as a mutual insurer or a prepaid health plan, is covered by the guaranty fund and holding company laws.

The NAIC will also seek to develop a supplemental filing form for the Blues -- a form that should be standard for all plans and suitable for use in calculating the financial ratios used in solvency analysis. The state insurance departments should also assess the desirability of requiring audited financial statements and the disclosure of executive compensation on the annual blanks. Further, the NAIC needs to undertake serious analysis of the Blues' risks, including the inter-plan bank; the Federal Employee Health Benefit Plan; quasi-national accounts; and the United Auto Workers account.

Q. Does the NAIC encourage the various States to cover the subsidiaries of these franchised Blue Cross Plans by the State Life and Health Guaranty Funds?

A. One of the issues the NAIC has been examining is whether to extend coverage under the state-based life and health guaranty funds to the Blues plans. Our Guaranty Fund (EX4) Task Force, in conjunction with the Special Committee, will evaluate expansion of and improvements to the guaranty fund system. The focus of the question on "subsidiaries" of the Blues plans is perplexing because the guaranty fund laws only pertain to entities promising insurance or prepaid health coverage.

Q. In his statement, Superintendent Willis suggests that consideration be given to establishing civil and criminal penalties applicable to insurance company officers and directors, who, by their actions or inaction abuse the public trust. Does the NAIC share this opinion?

A. As both the President of the NAIC and the Commissioner of Insurance for the Commonwealth of Virginia, I strongly agree with my colleague, Robert M. Willis, the Superintendent of Insurance for the District of Columbia. The NAIC and the state insurance regulators have enthusiastically supported establishing civil and criminal penalties for officers, directors, and employees of insurance companies who abuse the public trust. In April 1991, the NAIC initiated the call for a federal insurance-fraud statute by proposing criminal penalties of up to a $1-million fine, 30-year prison term, or both, for filing false reports and making false statements, embezzling money and premiums, theft, obstructing regulatory proceedings, and other violations. In addition, while the NAIC certainly geared its proposed criminal statute toward officers, directors, and employees of insurance companies, the NAIC would also have included outside professionals -- accountants, auditors, financial advisers, lawyers, etc. -- among those who could be held liable for such criminal offenses.

During the debate on the omnibus crime-control bill in the 102nd Congress, Senator Richard H. Bryan (D-NV) sponsored an amendment that included much of the NAIC's proposal, which the Senate incorporated in S. 1241, the "Violent Crime Control Act of 1991". The House-passed version of the anti-crime package, H.R. 3371, the "Omnibus Crime Control Act of 1991", included an insurance fraud amendment sponsored by Representatives John D. Dingell (D-MI) and Jack Brooks (D-TX). The House adopted similar, but not, identical language to that approved by the Senate, with the House opting for less severe criminal penalties. Eventually, a House-Senate conference committee produced a compromise between the two versions of the crime package. The conference report language more closely resembled the House-passed insurance-fraud provision, though the NAIC had urged the conferees to adopt the stronger criminal penalties. The House passed the conference report by a thin margin of 205-203 on November 27, 1991. The Senate, however, failed on several occasions in 1992 to pass this legislation because of controversy unrelated to insurance fraud. After the Senate failed for the third time to invoke cloture and turn to consideration of the conference report, Senator Howard M. Metzenbaum (D-OH) attempted to secure passage of the insurance-fraud provision and he

encouraged Senators Joseph R. Biden, Jr. (D-DE) and Strom Thurmond (R-SC) to include this proposal in S. 3349, the "Justice Improvements Act of 1992". Unfortunately, though the Senate quickly passed this package of noncontroversial proposals gleaned from the stalled crime bill, the House adjourned for the year without acting.

This year, on January 27, Representatives Dingell and Brooks reintroduced their version of the insurance-fraud statute, H.R. 665, the "Insurance Fraud Prevention Act of 1993". The language of H.R. 665 is similar to that in the conference report to the crime bill. We are hopeful that Senators Bryan, Metzenbaum, and perhaps others -- Senator Nunn, for example, has commented favorably on such an insurance-fraud statute on several occasions -- will introduce a similar measure in the Senate.

To repeat, the NAIC strongly supports making insurance fraud a federal offense. The NAIC will continue to work with the 103rd Congress for the adoption of the most effective legislation and for the strongest possible criminal penalties. We are convinced that tough federal criminal penalties are an appropriate punishment and a useful deterrent.

Q. In light of the extremely serious problems revealed by the Subcommittee's investigation thus far, what is the appropriate relationship between insurance regulators and the industry they oversee? For example, are existing NAIC policies and procedures regarding the acceptance of gifts and gratuities from industry interests adequate? Are any changes to strengthen them being considered and, if so, what are they?

A. The NAIC is an organization of statutory and constitutional officials from the fifty states, the District of Columbia, American Samoa, Guam, Puerto Rico, and the Virgin Islands. My colleagues, the NAIC members, are the chief insurance regulatory officials, and they are subject to the laws, regulations, and other rules of their own jurisdiction regarding accepting gifts and gratuities from any party.

As regulators, we are mindful of the negative public perception that can be created by industry influence at NAIC meetings and with individual regulators. The NAIC has recently made several changes to our policies in this area, including the elimination of industry funding of the commissioners dinner held at each NAIC National and Zone meeting. This change will begin with our 1993 Summer National Meeting, to be held in Chicago in June. The NAIC has also adopted a policy stating that regulators do not expect, invite, or encourage meals or other gratuities from industry representatives.

Q. According to the Special Committee's report,

> *Unlike most commercial insurers, most BC/BS Plans are not required to submit financial information to the NAIC and are not subject to other reporting*

requirements such as those for audited financial statements, actuarial opinions on reserve adequacy, and management discussion and analysis reports.

Why has this been allowed to occur, and do you foresee any changes regarding this practice?

A. The NAIC primarily developed its financial reporting and analysis functions to assist states in the regulation of insurers that operate interstate. Until recently, the NAIC has tended to view Blue Cross and Blue Shield plans as largely intrastate insurers. As a result, regulators from one state have usually not looked closely at the financial status of Blues plans operating in other states. Given the greater public concern over insurer solvency, as well as the important public-policy considerations underlying the operation of the Blues (i.e., insurer of "last resort" in many cases), the Special Committee is considering whether Blue Cross and Blue Shield plans should be subject to some or all of the reporting requirements applicable to commercial insurers.

As individual regulators responsible for the policyholders and claimants in our own states, and as NAIC members, we are dedicated to developing the most effective solvency monitoring system possible for the Blues plans. As you may know, some states have required the Blues to meet the same reporting requirements as those for commercial insurers. While a federal charter exempted BCBSNCA from financial oversight by the District of Columbia, in other jurisdictions, specific state statutes authorized the creation and operation of the Blues. In many cases, these states looked, and continue to look, upon the Blues almost as an extension of the state government, with the Blues having a mission of providing health insurance to everyone.

Q. In discussing the Blue Cross and Blue Shield Association's inter-plan service benefit bank and the associated reciprocity program, the report states,

The Special Committee has questions regarding whether controls over inter-plan bank accounting are sufficient to prevent plans from using the bank for purposes of disguising future claim obligations, and thus overstating plan surplus.

Does the NAIC have evidence that this occurred and, if so, with which Plans?

A. The NAIC is looking into large amounts of money owed to the inter-plan bank by the West Virginia Blues at the time this plan failed.

Q. How far along are State regulators in being able to assure their citizens that the insurance companies they oversee are individually and collectively subject to the same

standards? How important is it to you and your fellow State regulators that the citizens of one state not be subject to substantially greater or lesser benefits and/or safeguards than those in another?

A. Because of the NAIC's Financial Regulation Standards and Accreditation Program and the hard work of state regulators and insurance departments across the country, the last few years have witnessed a flurry of passage and implementation of new insurance laws and regulations. There has also been a substantial move toward greater uniformity and consumer protection in the area of solvency regulation. The NAIC has made the adoption of minimum financial laws and regulations for insurance solvency its top priority.

State insurance regulators, collectively and individually, will continue to emphasize safeguarding the solvency and financial condition of insurance companies, with an eye toward improving the system of regulatory protections for consumers, policyholders, claimants, and taxpayers. When a state can demonstrate that it meets the requirements of our Financial Regulation Standards and Accreditation Program, the NAIC formally acknowledges this achievement by accrediting this state. Accreditation signifies that a state insurance department has met the NAIC's rather extensive and demanding requirements, including compliance with the financial regulation standards -- standards designed to strengthen the ability of state insurance regulators to monitor the solvency of insurance companies. Effective regulation of the solvency and financial condition of insurers necessitates certain basic components. Insurance regulators should have adequate statutory and administrative authority to regulate an insurer's corporate and financial affairs, the necessary resources -- personnel, financial, and technical -- to carry out that authority, and organizational and personnel practices designed for effective regulation.

Personally, I am proud to note that the Commonwealth of Virginia is among the 19 states now accredited by the NAIC. In addition to Virginia, the NAIC has accredited the insurance departments in Alaska, Colorado, Florida, Illinois, Iowa, Kansas, Minnesota, Missouri, Nebraska, New Hampshire, New York, North Carolina, North Dakota, Ohio, South Carolina, Texas, Utah, and Wisconsin.

For the most part, the regulation of special statutory entities, such as Blue Cross and Blue Shield plans, has not been part of this movement toward increasing uniformity in insurance regulation. This results in part from the priority necessarily given to commercial insurers, which make up the bulk of the health insurance industry, and in part from the differences across the states in the mission and operation of Blue Cross and Blue Shield plans. As discussed before, the operation and regulation of the Blues plans differs considerably from state to state. For example, in a number of states, theses plans have (or until recently had) special statutory responsibilities as "insurers of last resort." In other states, Blues plans are constituted and operate as mutual insurance companies. Such

differences in plan operation have led states to develop unique responses to the regulation of these plans. This diversity has made it difficult to develop model laws and regulations that could be generally applicable to all Blues plans in every state and jurisdiction.

In its report, the Special Committee has recommended greater uniformity in the regulation of Blues plans. The NAIC will be moving forward on this charge this year.

Q. Do you systematically communicate with relevant Federal Agencies -- e.g., OPM, HHS, and DOD (for CHAMPUS) -- regarding their experiences with insurance companies? Do you share information with them to provide early warning about potential problems and how to deal with them?

A. In matters of state licensing authority and jurisdiction, the Virginia State Corporation Commission/Bureau of Insurance has worked on numerous occasions with both the Office of Labor Racketeering and the Pension and Welfare Benefits Administration, Department of Labor, regarding so-called multiple employer welfare arrangements (MEWAs) and the Employee Retirement Income Security Act (ERISA). Solvency concerns regarding federally-qualified health maintenance organizations licensed in Virginia have prompted discussions between the Office of Prepaid Health Care Operations and Oversight, Department of Health and Human Services (HHS), and the Virginia State Corporation Commission/Bureau of Insurance. We have had extensive discussions with the Office of Civilian Health and Medical Programs of the Uniformed Services (CHAMPUS), Department of Defense (DOD), regarding pilot projects in managed care.

We regularly refer Virginia complainants whose complaints deal with federal programs to the appropriate federal agency for handling. For example, complaints dealing with ERISA-qualified plans or MEWAs claiming to be exempt from state regulation pursuant to ERISA are referred to the Department of Labor (DOL) for opinion and/or investigation. The Bureau's own investigatory staff works with DOL investigators in such matters. Pursuant to the Omnibus Budget Reconciliation Act (OBRA) of 1990, we will be reporting all Medicare Supplemental Insurance complaints, on a quarterly basis, commencing with the first quarter of 1993, to the Health Care Financing Administration (HCFA).

The NAIC and the state insurance departments communicate formally and informally with a number of federal agencies. For example, the NAIC has provided the principal parts of its computer database, including financial information and annual statements from nearly 5,500 insurance companies, to the Department of the Treasury, the Federal Reserve Banks of Boston and New York, and the General Accounting Office. Other agencies and departments, including the Office of Management and Budget, the

Securities and Exchange Commission, the Department of Commerce, and the Department of Labor, have received significant portions of this computer database.

The NAIC works closely with HHS on issues such as the Medicare Supplemental Insurance program. In particular, the NAIC provides the financial information collected by the states to HCFA.

Further, the NAIC continuously exchanges information with the Department of Justice, especially the Federal Bureau of Investigation, and the offices of various United States Attorneys. The NAIC's Legal Division includes the Special Services Coordinator. This person functions as a direct liaison among state, federal, and international law enforcement authorities and acts as a repository and a conduit for the exchange of information on individuals and companies of special regulatory concern.

While there might not be a formal system of communication about specific insurance companies and potential problems between state regulators and federal agencies, including the Office of Personnel Management, HHS, and DOD, if requested, the NAIC would supply the same type of information to these and other federal departments and agencies that would be available to any policyholder. Such information would include public examination reports and other public information regarding the performance of insurance companies.

Q. Do your regulations allow a BCBS Plan to sell health insurance on the condition that the client also purchase life insurance? If so, would you explain the rationale for your position in this regard?

A. Neither of the Blue Cross and Blue Shield plans authorized to do business in Virginia is licensed to sell life insurance directly. Therefore, neither would be permitted to engage in such marketing methods.

Currently, Virginia law and regulations, however, would not prohibit this practice in the event that either Blue Cross and Blue Shield plan obtained such license authority. Blue Cross and Blue Shield of Virginia, as a mutual insurance company, would be permitted to apply for authority to sell life insurance, but this plan has not done so to date. The District of Columbia Blues, GHMSI, licensed as a health services plan under Virginia law, would not be permitted to apply for or receive such authority.

The NAIC recently adopted model regulations that would prohibit conditioning the purchase of health insurance on the purchase of any other insurance or product in the small-group marketplace. The Market Conduct and Consumer Affairs (EX3) Subcommittee is looking at that same issue outside of the small-group marketplace. In

addition, a number of states have antitrust laws that could prohibit tying together products in certain circumstances.

Q. In 1989, the Virginia Insurance Department changed its previous policy and allowed GHMSI to report its headquarters building at its appraised value. This meant that instead of the previously reported value for its real estate at $8.4 million, GHMSI reported real estate at $90 million. The effect of this change, in turn, was to increase GHMSI's statutory reserve by over $80 million. Why was this change made? Who initiated it? Do you agree with it?

A. This change was a result of the real estate valuation law in effect during 1989. This law required that the Virginia State Corporation Commission/Bureau of Insurance accept GHMSI's reporting of its home office at market value if GHMSI could produce a reliable appraisal.

GHMSI initiated the change in valuation.

As a result of this experience with GHMSI, I drafted legislation to close this loophole and the Virginia State Corporation Commission sponsored the bill. Effective July 1, 1990, Virginia law was amended so as not to require acceptance of write-ups to full market value. However, GHMSI's valuation did enjoy a "grandfathered" status under the new law and this company was not forced to write down the building.

Q. Is this an appropriate way to increase an insurer's reserves, especially if it becomes a high percentage of the overall amount? In this respect, how safe is it to rely on assets, such as real estate, that lack liquidity?

A. The law in effect at the time required that the Bureau accept GHMSI's reporting of its home office at market value. Liquidity is a major concern in judging an insurer's solvency. GHMSI's overall lack of liquidity has been a major concern of the Bureau, especially in light of the company's diminishing reserves. Because of its lack of liquidity and other matters, GHMSI agreed to a Consent Order, which among other items, specifically addressed GHMSI's lack of liquidity. GHMSI was required to submit a detailed plan to effect the sale or otherwise liquidate its real estate holdings to the extent necessary to provide adequate liquidity. In its response, GHMSI represented that it had developed three plans to ensure that it had adequate liquidity, both short-term and long-term.

It is not safe to rely on illiquid assets to provide liquidity.

Q. GHMSI was involved in several joint ventures with foreign insurance carriers, in which the latter would sell the product and GHMSI would accept up to 100% of the risk. Is this

normal activity for a Blue Cross Blue Shield Plan? How do you regulate this type of activity? Does this cause you some concern about the potential liability of the DC Plan?

A. Although I have not surveyed Blue Cross and Blue Shield plans across the country, I would assume that this is not a widespread activity of Blue Cross and Blue Shield plans.

This activity is regulated through holding company filings; analysis of monthly, quarterly, and annual financial statements; periodic financial condition examinations; and audited statutory certified public accountant reports.

Yes, we are concerned about the potential liability of GHMSI. It appears that the management decision to enter into foreign/alien markets was done without the benefit of credible actuarial data or sufficient expertise to help ensure profitability from adequate rates.

I believe this completes the additional questions submitted for the record following the Permanent Subcommittee on Investigations' hearing on GHMSI. If you require any further assistance, please do not hesitate to call upon the Virginia State Corporation Commission/Bureau of Insurance, the NAIC, or me.

Sincerely yours,

Steven T. Foster
President, NAIC
Commissioner of Insurance
Commonwealth of Virginia

cc: The Honorable William V. Roth, Jr.
Mr. David B. Buckley
The Honorable Robert M. Willis
David B. Simmons, Esq.

{O:\legis\congress\q&A.doc}

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF CONSUMER AND REGULATORY AFFAIRS

INSURANCE ADMINISTRATION
POST OFFICE BOX NUMBER 37200
WASHINGTON D C 20013-7200

MAY 10 1993

Mr. David B. Buckley
Chief Investigator
Permanent Subcommittee on
Investigations
United States Senate
Washington, D.C. 20510-6250

Dear Mr. Buckley:

Enclosed are responses to the questions presented in your February 4, 1993 correspondence. My understanding is that these questions and responses will be made a part of the official record of the hearing before the U.S. Senate Permanent Subcommittee on Investigations held on January 26 and 27, 1993, regarding the financial condition of Group Hospitalization and Medical Services, Inc. ("GHMSI").

For clarity, I have restated each question and provided an appropriate response. In addition, where I felt a question was more appropriate for the National Association of Insurance Commissioners ("NAIC") to respond to, I have so indicated.

Question 1.:

The Subcommittee is in receipt of a complaint from a subscriber of Blue Cross and Blue Shield of the National Capital Area. The complainant's group insurance coverage was altered by the Plan by way of a general letter from the Plan. Now that your office has regulatory authority over the Plan, will the Plan have to submit its policies and contracts to your Department for review and approval? Will changes in contracts and policies have to be approved by your Department? How will the consumer be protected from the corporation changing or amending its contracts after the consumer has paid the premium?

Response:

This question references a complaint filed with the Subcommittee by a subscriber of a Blue Cross and Blue Shield group contract. The Complainant has asked that his name be kept confidential and stated that he is preparing for litigation on the issues presented. Therefore, I will not comment on the particulars of the complaint.

However, for the record, I believe it is important to point out that GHMSI was not regulated by the District of Columbia when this contract was executed or when the alleged violations occurred. I would also point out that this complaint was not filed with my office.

In fairness to the parties involved, I will not speculate on the merits of GHMSI's refusal to pay for a particular treatment. Discussions concerning the treatment of the Complainant's medical condition have a long history at both the federal and state level. As far back as 1965, Medicare and Medicaid have wrestled with this particular issue. My understanding is that the debate is ongoing.

Since the primary issue raised by the Complainant concerns GHMSI's contractual right to amend a subscriber contract, I will reserve comment on this pending legal question until the court has had an opportunity to render its opinion.

Question 1a:

Now that your office has regulatory authority over the Plan, will the Plan have to submit its policies and contracts to your Department for review and approval?

Response:

Yes, the Plan is currently required to submit its subscriber contracts to the District of Columbia's Insurance Administration for review and approval.

Question 1b:

Will changes in the contract and policies have to be approved by your Department?

Response:

Yes, changes in the subscriber contracts and policies will have to be submitted for approval by the Insurance Administration.

Question 1c:

How will the consumer be protected from the corporation changing or amending its contracts after the consumer has paid its premium?

Response:

The corporation will not be permitted to unilaterally change or amend its contract during the contract term, unless this right is specifically reserved. Generally, such right to amend the terms of the contract are reserved on a renewal basis.

Question 2:

The Subcommittee has received complaints from consumers who said they were forced to purchase life insurance from GHMSI's life insurance company as a precondition for health insurance provided by BCBSNCA. Is this practice legal? Should persons desiring health insurance coverage be forced to purchase life insurance from the same company?

Response:

The Insurance Administration would not authorize an insurer or a health service plan to condition the sale of health insurance or subscriber contracts on a requirement to purchase life insurance. Persons desiring health insurance coverage should not be forced to purchase life insurance, as a condition of sale, from the same company or any other company. In many instances, life insurance is offered as part of a group contract. Employees are not required to make this election.

Question 3.

In light of the extremely serious problems revealed by the Subcommittee's investigation thus far, what is the appropriate relationship between insurance regulators and the industry they oversee? For example, are existing NAIC policies and procedures regarding the acceptance of gifts and gratuities from industry interests adequate? Are any changes to strengthen them being considered and, if so, what are they?

Response:

This question is more appropriately addressed to the National Association of Insurance Commissioners. To aid in obtaining your answer, I encourage you to correspond with:

National Association of Insurance Commissioners
Attn: Steven Foster, President
120 West 12th Street
Suite 1100
Kansas City, Missouri 64105-1925
(816) 842-3600

Question 4a:

How far along are State regulators in being able to assure their citizens that the insurance companies they oversee are individually and collectively subject to the same standards?

Response:

Through the NAIC accreditation program States and the District of Columbia are required to adopt minimum standards of financial regulation. The completed implementation of this program will provide insurance consumers certainty that the NAIC financial solvency and other uniform standards apply to all insurers regardless of their location. To date, nineteen states have accredited.

In my opinion, the more critical protections for insurance consumers are the state regulator's enhanced ability to adapt to changing market conditions affecting competition and to conduct continuous solvency surveillance.

Question 4b:

How important is it to you and your fellow State regulators that the citizens of one state not be subject to substantially greater or lesser benefits and/or safeguards than those in another?

Response:

Ultimately, the determination of benefit levels will be based on the level of competition within a particular state and "so-called" mandated benefits required by local law. Since competitiveness and local laws vary from state to state, there will always be differences in benefits as well as the safeguards employed to protect consumers. Benefits will vary by company and jurisdiction.

However, what is clear is that there is a direct correlation between mandated benefits and the price of insurance. If benefits in each jurisdiction were required to be uniform, the cost of insurance would rise artificially without an assessment of local needs or the ability to afford such systems.

I think consumers will continue to dictate the level of insurance benefits and cost through their purchasing decisions. The role for state regulation is to ensure that the benefits purchased are, in fact, provided on a low costs and non discriminatory basis and that sufficient competition exists in the marketplace to maintain these results.

Question 5a:

Do you systematically communicate with relevant Federal Agencies -- e.g., OPM, HHS, and DOD (for CHAMPUS) -- regarding their experiences with insurance companies?

Response:

Although there is no systematic communications with the referenced federal agencies, we make every effort to keep abreast of the insurance, pension and health related activities of these agencies. Quite frankly, our efforts are often stifled because of our inability to obtain information from the various federal agencies. Let me give you some examples.

We routinely, and without cost, obtain reports from the General Accounting Office (GAO). Those reports are extremely helpful to the regulatory process because of their in-depth analysis. However, we frequently encounter difficulty in obtaining the references identified in GAO reports. Many of the references are reports of federal agencies that do not make their studies available free of charge. The price barrier often prevents this Administration from getting a handle on the regulatory impact of proposed changes in federal law that very often occur as a result of GAO studies.

We routinely refer complaints to U.S. Department of Health and Human Services (HHS) from participant enrolled in federally approved HMOs. However, HHS does not provide the Insurance Administration the data requested about the activities of these HMOs. Given the overall objective to contain costs, state local insurance regulators should have access to information about HMOs which are a part of the federal health care delivery system.

The Health Care Finance Administration (HCFA) publishes guidelines, studies and statistical information concerning Medicare and Medicaid. This information is relied on by

insurers, HMOs managed care companies and utilization review organization. The Insurance Administration is unable to obtain, without charge, any of the above described information. Given the volume of information, and the degree of reliance by insurers, it is very important for state regulators to have access to this information at no cost.

As you know, the Medicare Supplement Insurance market is regulated by states and the District of Columbia. However, the pricing information submitted by insurers is based on HCFA data. In my opinion, the regulatory process is somewhat usurped if regulators must rely on insurers to provide us HCFA data. Alternatively, the regulatory process would be significantly enhanced if state regulators had full access to HCFA data to make an independent determination concerning the appropriateness of its use in estimating pricing.

There is no communication with Department of Defense (DOD) concerning CHAMPUS or the sale of insurance products to military personnel. At best, we only communicate by forwarding complaints to DOD by insureds covered by CHAMPUS.

Question 5b:

Do you share information with them to provide early warning about potential problems and how to deal with them?

Response:

Unfortunately, communication procedures or protocols have not been established with these federal agencies to provide early warning about potential problems. The only exception is the Department of Labor which notifies this Administration about non-MEWA (Multiple Employer Welfare Arrangements) activities in the District of Columbia.

Question 6:

GHMSI was involved in several joint ventures with foreign insurance carriers, in which the latter would sell the product and GHMSI would accept up to 100% of the risk? Is this normal activity for a Blue Cross Blue Shield Plan? How do you regulate this type of activity? Does this cause you some concern about the potential liability of the DC Plan?

Response:

The normal business activity for Blue Cross and Blue Shield Plans is selling of individual and group subscriber contracts in a specific market. This ordinary course of business does not

involve such plans entering into joint ventures with foreign insurance carriers or assuming 100% of such risk.

The idea of entering into contractual relationships involving joint ventures or foreign insurance carriers should not be viewed as prohibited conduct. What should be prohibited is the entering into any contractual relationship, without regulatory approval, that has the potential of exposing the Plan's core business to an increased risk of loss arising out of speculative contracts.

If a Plan engages in the proper due diligence of assessing the feasibility of engaging in this kind of business opportunity and adequately presents such matters for regulatory approval, I see no reason for unilaterally prohibiting such transactions. I think, however, that regulatory approval would require that the transaction should not subject subscribers to an increased risk of loss. No corporation engaged in the business of providing health insurance should insure 100% of such risk.

I have candidly responded to your questions. If you need additional information or have any further concerns, please contact me at (202) 727-8000.

Sincerely,

Robert M. Willis

Robert M. Willis
Superintendent of Insurance

SUBSIDIARY/GHMSI SPONSORED EVENTS

BCBSNCA

1988	
$2,875	Presidential Classroom for Young Americans
$10,000	Sponsorship for three Olympic Athletes in return for personal appearances representing the Plan (In addition to sponsoring three athletes, the Plan's employees raised the funds used to meet BCBSNCA's share of BCBS System's sponsorship of the U.S. Olympic Team.)
$200,000	Beautiful Babies: Right From the Start/prenatal education incentive program
$2,381	Walt Disney Physical Fitness Films/ Final payment of a multi-year program to place films free in local school systems
1989	
$3,200	NFL Alumni Charity Golf Classic
$162,819	Drug Free Zones/Drug education and prevention program
1990	
$18,500	Beautiful Babies: Right From the Start
$1,200	Joe Jacoby Celebrity Golf Tournament
$1,500	Breast Cancer Awareness Awards (Columbia Hospital)
$1,600	NFL Alumni Charity Golf Classic
$3,500	Olympic Fundraising dinner, sponsored by BCBS Association and USOC
1991	
$229,000	Drug Free Zones
$6,750	March of Dimes Golf Tournament
$3,000	Have a Heart Foundation
$10,000	Olympic Fundraising Dinner sponsored by USOC and Congressional Olympic Caucus
$500	Marymount University Inaugural Golf Outing, benefitting Marymount University
1992	
$147,000 (estimate)	Drug Free Zones
$450	1st Annual Greater Association of Health Underwriters, benefitting the Childrens Hospital and Special Olympics, August 31, 1992
1990-1992	Sponsor with other BCBS Plans of U.S. Olympic Team. BCBSNCA employees raised approximately $37,000, covering BCBSNCA's share of BCBS System's sponsorship as well as $15,000 for sponsorship of three local Olympic athletes.

CAPITALCARE

1988	
$5,000	Contribution to the U.S. Olympic Committee
$343,000	CapitalCare ran television ads in association with the 1988 Olympics during September and October 1988. Based on the ads, CapitalCare was given some free tickets to the Olympics. CapitalCare sponsored an essay contest in local schools and awarded the tickets to the winner of the contest.

EMTRUST

1988	
$1,000	Kemper Open
1989	
$440	Kemper Open
$400	Northern Virginia Charity Golf
1990	
$4,200	Kemper Open
1991	
$4,200	Kemper Open
$2,500	McLean/Tysons Optimist
1992	
$2,500	McLean/Tysons Optimist
$2,500	McLean/Tysons Optimist

PROTOCOL

1989	
$800	Project Hope
$15,000	Meridian House Ball
$10,000	UNA/USA
$1,000	Orphan Foundation of America
1990	
$25,500	Merdian House International
$1,500	Friends of Pakistan Gala
$8,000	U.S. Committee for Unicef
$15,460	Virginia Gold Cup
$5,000	Multipel Sclerosis Society

$6,000	Africare
1991	
$5,000	Friends of Pakistan
$38,500	Merdian House International
$3,000	Africare
$22,662	Virginia Gold Cup
$3,000	B'nai B'rith Foundation Dinner
1992	
$7,750	Meridian House International
$20,000	Virginia Gold Cup
$600	The Third Africare Bishop John T. Walker Memorial Dinner

INSURANCE DIVISION

1990	
$1,495	Reach America Drug Awareness Program/DCLUA
$400	26th Annual CMGA Member-Guest Tournament 1990 Sponsorship fee for the Crofton Men's Golf Association
$918	Advertisement in the 1990 Kemper Open Program/design
$2,200	Advertising in the 1990 Kemper Open Program
$1,500	United States Committee Sports for Israel/Golf Tournament
1991	
$500	Crofton Men's Golf Association/sponsorship (AMCAP)
$3,100	Ad in Kemper Open Program
$1,100	Kemper Open pairing sheet ad
$2,000	Boy Scouts of America/ 1991 Annual Golf Classic
$1,000	Washington Bullets: I Have a Dream Foundation two-day event
1992	
$1,000	Boy Scouts of America/1992 Golf Classic
$2,200	Kemper Open Pairing Sheet ad
$1,500	U.S. Committee Sports for Israel/golf outing
$400	U.S. Olympics/Use of Tournament Players Club of Avenel for the winner of an Olympic Fund Raising Event

BLUE CROSS OF JAMAICA

1989

$90,000	Jamaica Teachers' Association
$30,000	Medical Symposium
$172,800	Health Watch (TV program)

1990

$90,000	Jamaica Teachers' Association
$42,000	Medical Symposium
$207,360	Health Watch

1991

$90,000	Jamaica Teachers' Association
$50,000	Medical Symposium
$55,000	Nurses Association of Jamaica/International Council of Nurses Conference
$343,200	Health Watch

1992

$90,000	Jamaica Teachers' Association
$65,000	Medical Symposium
$444,840	Health Watch

CASCI

1992

$25	Corporate Cup

ISBN 0-16-041007-X
90000
9 780160 410079